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MENTAL HYGIENE

VOLUME V
1921

PUBLISHED BY
THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.
370 SEVENTH AVENUE, NEW YORK CITY
1921

The National Committee for Mental Hygiene

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When one considers the large groups of people who may be benefited by organized work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live happy and efficient lives.

QUARTERLY MAGAZINE
OF
THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.
370 SEVENTH AVENUE, NEW YORK CITY

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Subscription: Two dollars a year; fifty cents a single copy. Correspondence should be addressed and checks made payable to "Mental Hygiene," or to The National Committee for Mental Hygiene, Inc., 370 Seventh Avenue, New York City.

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MENTAL HYGIENE

VOL. V JANUARY, 1921 No. 1

THE BEHAVIORISTIC ATTITUDE*

WILLIAM A. WHITE, M.D.
Superintendent, St. Elizabeths Hospital, Washington, D. C.

I HAVE been asked to approach the problem of community work from the standpoint of behaviorism, as it is called, and to outline such of the fundamental assumptions of modern psychology as may be of practical service to the community worker, enabling such worker to function more intelligently. In order that I may do this, I must first outline what I conceive to be the behavioristic attitude.

Behaviorism looks upon what a man does in contrast to what he thinks and feels—that is, upon his conduct—as being the most important expression of his psychology. In other words, his actions are taken as the only authoritative expression of what he is. Thinking and feeling have significance only so far as they are preparatory for and lead to action. The man who thinks and feels, but does not translate his ideas and emotions into action, is hamstrung by doubt; he is unable to choose among the several possibilities presented to him; out of the mass of possible actions he has not been able to choose one, and so his true self does not stand revealed. His powers of expression are "sicklied o'er with the pale cast of thought." Behaviorism believes that "by their deeds ye shall know them." However, I would remind you, in passing, that failure to act in the ordinary sense is itself action. A body comes to rest only because the forces that act upon it are for the time being in equilibrium.

* Lecture given in the training course for community workers, Columbia University, New York, September 30, 1920.

It is from this behavioristic standpoint that I have been asked to speak to you and to outline the general approach and fundamental assumptions of psychology—from the point of view, in other words, of man in action, or, as I should prefer to say, of man as a complex of action systems. In order that you may get my point of view, I will devote a few words to a historical restrospect of the factors that led up to the behavioristic movement in psychology.

The behavioristic psychology was one of those forward-looking efforts which were calculated to get beyond the concepts of the old academic, metaphysical type of psychology of a generation ago, and it was not satisfied by the physiological approach to its problems introduced by the Wundtian school. It was dominated by the need to get away from the necessity of dealing with involved introspections, which so frequently quickly gained a metaphysical ground, for it saw psychology as one of the biological sciences, not confined by any means to *homo sapiens*. The biological point of view necessarily involved the study of psyches other than human and made, therefore, the objective approach a necessity. In the study of animal psychology, the subject could not be interrogated in the usual way, but could be studied only in action, and thus there grew up that observational method which later came to be applied to man. This behavioristic attitude has distinct advantages and has been a useful variant in the course of psychological progress; it was a distinctly warranted new method because the old academic psychology had become sterile when it came to having anything helpful to offer in the solution of man's vital problems of living. It had nothing to say when it came to face his actual, practical problems, nothing to offer that was helpful in solving his difficulties or even in explaining their nature. It had come to be essentially a laboratory discipline occupied largely with questions of neuro-physiology and the physiology of the special sense organs.

The outstanding fact—the fact that the behavioristic viewpoint threw into high relief—is the fact that organisms are constructed on a pattern which has action for its purpose. Life itself has been defined as consisting of that constant back-and-forth flow of energy which constitutes the relation of the organism to its environment. Every change in the environment must be met by an adjustment on the part of the organism, and that adjustment involves action, or, expressed in physiological terms, reaction. The adjustment effected brings the organism into functional contact with the environment at more points than before and therefore necessitates further reactions of adjustment, the growing number and complexity of which constitute development in the individual and evolution in the race.

This fact alone justifies the emphasis of the behaviorists on conduct, and what you as community workers will have to deal with in essence will be the failures of individuals to meet the conditions imposed upon them by their environment, largely their social environment—to effect adequate reactions of adjustment. You will see the results of actions that were calculated to make such adjustments, but have, for one reason or another, failed more or less completely. The criminal, for instance, is one who, in order to meet certain requirements of his nature and at the same time retain a certain social standard, acts in a way that is more or less out of harmony with social standards and to that extent fails to effect an efficient adjustment. His social standards, to be sure, are not those of the law-abiding citizen, but they spring from the same motives. He needs to provide for himself and family, so he steals; he is proud or rather vain, so he wears loud clothes; he likes to be looked up to by his associates, so he effects bravado and strives for skill in his particular line of work.

The great change that has come over psychology in recent days is that it has been humanized. In the days when psychology was metaphysical and academic, it was a subject for meditation in one's study; it had, strangely, almost no touch with the living, pulsing problem of human life. It was more interested in discussions of the nature of the soul than in such questions as why men failed in life. Failure of any kind was hardly recognized as a biological problem of adjustment, and so its real psychological significance failed of appreciation. Now, however, the whole tendency has changed, and it is just such problems as the criminal, the insane, the defective, the vagabond, the prostitute, the neurotic, and all sorts of minor disabilities that interest it most, and these are the same problems that occupy the focus of your attention.

To come to the question of the Why of some of these failures and your relation to them, to revert to the fundamental behavioristic conception of man as a complex of action systems or action patterns, one of the very obvious reasons for failure lies in the fact that the machinery which a man has at his command—and by this I mean his bodily machinery, his vital organs in all their complexities and intricate interrelations—is inadequate to the carrying out of a socially acceptable life plan. Bodily illness of one sort or another, chronic and disabling diseases of the vital organs—the heart, the lungs, the kidneys—make the demands of his environment beyond his powers of adjustment. An astonishingly large percentage of the unfit, the social outcasts, are seriously handicapped by bodily disease, while approximately 50 per cent, I think, of all classes are as seriously impaired by obvious or comparatively easily discoverable mental disease. What has a behavioristic psychology to say to this fact? In the first place, the two classes are not so widely separate as my statement would lead you to believe. The metaphysical distinction between mind and body, which still persists in many quarters, would lead to a definite separation. From the behavioristic point of view, which is concerned only with conduct, they would both appear as groups that failed to meet their problem of adjustment efficiently. The court of last resort, which passes upon all the issues of life, is the psyche, and the psyche has failed in both instances. Physical disease merely introduces a specific form of problem to be met, and the individual has been mentally incapable of handling it. We all know instances of men who have become beggared because they have lost the use of an arm or their sight, but we all also know instances of men who have risen superior to such disabilities and succeeded despite them, while some of us may know of those who have even succeeded because such misfortune has come to them. We have passed out of that stage of evolution in which success was solely a matter of blood and brawn, strength to kill or fleetness to escape, and are living in a period in which the struggle for survival, for success, is a contest of wits, a matter of brains. Therefore we may look upon failures of adaptation as predominantly failures at the psychological level. Here you will see I have grouped all maladjustments, whether they be of apparently physical—that is, bodily—or of mental origin, as finally psychological. This may seem a rather extraordinary thing to do, but it is justified so long as we look upon action as the final expression of the organism. The psyche is not something that has been added to man somewhere in the course of his development from embryo to adult, nor yet is it something that has been added somewhere in the course of the biological evolution of the species. Every organism, no matter how simple, even though it be only unicellular, has a head end that is the first to push its way into the environment. This head end is the central office, if you will, the center which operates to control and direct all the activities of the organism as a whole, as a biological unity, and serves as the final station where all its several parts are integrated for those functions in which it, as a unity, must needs engage. It contains—or rather it consists of, is made up of, is—the final collected integration of the action systems of all its parts. The organism is, therefore, something more than a collection of organs; it is a collection of organs that are related in such a way that they may all, like the several parts of a complicated machine, be brought into the service of a common purpose, and the head end is the device from which emanates the directing force for such integrated activities.

Body and mind, therefore, are in no sense separate, one from the other, they occupy no different temporal relations in development, the one has neither preceded nor followed the other; they have grown up and evolved together as part and parcel of the same thing, the one consisting of the parts, the other of the integrated relation of the parts.

Behavior, conduct, then, is seen to be of necessity the final expression in action of the whole, and so to have the importance that the behaviorists attach to it. Defects in the individual—whether they be of mental or of bodily origin, whether they depend upon mind in the first instance or are traceable and dependent upon some defect of an organ, such as blindness—ultimately find their expression in conduct.

This latter statement requires amplification. The failures with which you will have to do are all really failures that involve the individual in his social adjustment. They are not, despite the fact that they often appear to be, solely individual affairs; they are defects at the level of adjustment between the individual and his fellows, or at the psycho-social level. It is because this is so that the large class of unfit are social problems. A defective individual, for instance, because of his defect is unable to measure up to the standards of behavior that are set by society; he is poor, ill fed, lives in unsanitary and crowded conditions, is more liable to become the victim of disease, which disease, under such circumstances, is more apt to spread; he suffers because of his privation and may turn to alcohol or to crime for relief. In his struggles to effect an adjustment, he turns to all sorts of activities that are antisocial, and so in innumerable ways becomes in his community a focus for moral and physical disease, which not only threatens him with destruction, but is also a serious source of danger, as a result of his acts and example, to others. He is distinctly out of alignment with the tendencies that make for social progress and thus becomes a menace to the community in which he lives. The defective spreads moral and physical contagion, and just as the science of hygiene had its inception in the effort to clean up the pest holes of the big cities and manufacturing centers because of their danger to the community, so mental hygiene has now come forward to eliminate or render harmless the menace of mental defect; and it is realized that much of the former evil is dependent upon the latter. Take, for example, the venereal-disease problem. This deals with a class of diseases that are peculiarly destructive and that are disseminated by the prostitute. Now we know that a large percentage of prostitutes are feebleminded, and so we are beginning to appreciate that one of the most hopeful single approaches to the venereal-disease problem is by way of a more effective handling of the problem of feeblemindedness in the community. You will notice how immediately, as soon as we begin to deal with a problem of mental deficiency, we find it showing its teeth at the social level, how soon behavior that is inadequate to effect social adjustments becomes a social menace.

The same thing is true of less manifest disorders at what is usually supposed to be the psychological level. Take, for example, the person who is more or less crippled in efficiency as the result of a neurosis or mild psychosis. Such a person, living in affluent circumstances, may seem to do no harm, but as a member of a poor and struggling family, he soon becomes a serious burden that may easily spell the difference between comfortable circumstances and a continuous fight for the bare necessities. Even in the former case, a neurotic person in the household necessarily becomes a burden to some degree, and to that same degree detracts from the fullest usefulness of the others, who must spend time and energy in meeting the problems thus created. All this you see from the standpoint of behavior, conduct, as the final measure of effectiveness of the individual.

These illustrations of the relation of the individual to society suggest at once an analogy between society, as composed of individuals, and the description I have already given of the body as composed of organs. In fact, we are dealing here with a situation that is something more than just an analogy. Society would be a meaningless term if its component individuals were not related in some way, if each functioned independently. The organism could not long survive such a dislocation of its several part functions, and society would be in a state of anarchy if the direction and control of its institutions were destroyed.

Now society has always, heretofore, been primarily and, for that matter, solely interested in the conduct of its members, in their acts, and whenever it has found some one doing things that tended to its disadvantage, it has sought to put a stop to such acts with very little thought of the actor, the doer of the act. At one time, for example, and that not so very long ago, there were over two hundred offenses on the statutes in England punishable by death, and the statutes were not inoperative by any means.

This is the method of eliminating the source, and is the natural way to proceed at first when nothing is seen but the obvious connection between the destructive result and its immediate cause. It is as if you should consult a physician for a pain in your leg and he should at once relieve you of the offending member by amputation. That was the way society dealt with its criminals in those days. To steal anything of the value of two shillings was a capital offense. It is the way, too, in which surgery has dealt—and, I have no doubt, is still dealing—with many of its problems. It is the easiest way—for the surgeon. For example, innumerable ovaries were sacrificed in my college days because the patient had pain in the ovarian region. Now we know that the pain, in many instances at least, was psychological. The surgeon was trying to cut out a psychosis. When, however, the functions of the ovary came to be better known, it was realized that the cure was often worse than the disease, and so the practice ceased. What would you think of a watch maker to whom you took a watch with a broken mainspring and whose remedy was to remove the spring?

The same thing, however, has happened here as elsewhere. With increased knowledge, there has come a realization that there are other ways to tackle the problem that are more rational and bid fair to attain better results. The tendency in dealing with the delinquent, defective, and delinquent classes to-day is a tendency toward a greater individualization, a tendency to become more intimately acquainted with each individual problem, to deal, in other words, with the actor rather than with the act.

You community workers are like the trouble man employed by large business concerns. When any trouble arises with a customer—failure to deliver goods ordered, failure of goods to come up to quality agreed upon, dispute over the items in a bill—the trouble man is sent for to effect an adjustment. It is the same in the machinery of society as it is in the machinery of business. Whenever the machine does not work well, whenever there is lost motion, hot bearings, or a broken part, some one is sent to repair and adjust it. Now it is just about these inefficients that defects in the social machine come to view. They are the weak points in the mechanism, and so, when anything goes wrong, it is more apt to go wrong about them than anywhere else because they are less able than the other parts to bear the stresses and the loads of social demands. It is your job to see if some working compromise can be effected, some adjustment that will be socially acceptable at least, if nothing more.

Now as to the matter of effecting the necessary readjustments. Up to this point it is evident that the matter of adjustment is one of the mechanistics of the relation of the individual to his fellows, his community. But what kind of an individual is it that gets so out of touch with his community? A study of his conduct, his behavior, will indicate that he is, in some way, an undeveloped person—one who, in his conduct, manifests ways of adjustment that are, relatively speaking, infantile. The whole problem of the dependent, defective, and delinquent classes is, to my mind, most helpfully looked at from this point of view, as exhibiting undeveloped types of reaction, reactions whose inadequacy lies in the fact that they are relatively infantile. We have to deal, therefore, with a group of people who need to be helped to grow up. They do not need education in the ordinary sense of schooling, but they do need guidance and direction along the pathway that leads to more adult standards of behavior. What are some of the assumptions with which we must approach this effort?

In the first place, it is a fair assumption that every one desires to do better than he is doing. He not only wants to be more successful, but he wants to stand higher in the esteem of his fellows, even though his fellows may not represent a high standard of social efficiency. We must assume this because the very structure of society is based upon this forward-reaching tendency—yes, even life itself is expressive of this striving. Secondly, it is necessary to study the situation as thoroughly as possible in order to be able to define wherein the defect consists. The real defect may not reside at all where it seems to. An ineffective person may present evidences of a profound neurasthenic state coupled with tremendous ambition and bright ideas, when in reality the key to the situation is disclosed in the fact that he is a drug habitué. Then finally it is necessary to study the individual himself, in order to discover the nature of the difficulties within him that make for his poor social adjustments.

It is at this point that I part company with the extreme behaviorists, who would discredit the internal evidence entirely. It is true that "actions speak louder than words," and that when an action does occur, it is itself the best evidence of what the actor at that moment is, but it is a long way from this statement to the ability to see in acts their too, in which surgery has dealt—and, I have no doubt, is still dealing—with many of its problems. It is the easiest way—for the surgeon. For example, innumerable ovaries were sacrificed in my college days because the patient had pain in the ovarian region. Now we know that the pain, in many instances at least, was psychological. The surgeon was trying to cut out a psychosis. When, however, the functions of the ovary came to be better known, it was realized that the cure was often worse than the disease, and so the practice ceased. What would you think of a watch maker to whom you took a watch with a broken mainspring and whose remedy was to remove the spring?

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It is at this point that I part company with the extreme behaviorists, who would discredit the internal evidence entirely. It is true that "actions speak louder than words," and that when an action does occur, it is itself the best evidence of what the actor at that moment is, but it is a long way from this statement to the ability to see in acts their true meanings. Theoretically, to be sure, one should be able to do this, and some day perhaps it will be possible, but in the meantime there can be no objection to finding out what the internal evidence has to offer. Truly this evidence is itself not necessarily any easier to read than the act, but it is so much in addition and is helpful to that extent and also because it furnishes corroboration or otherwise of the other evidence. It should not be lost sight of that a very important part of the internal evidence does not consist in introspection, but in the conditions of the internal organs disclosed by clinical methods of examination. The evidence derived from this source, no less than that from introspective sources, helps to an evaluation of the individual's equipment and to the disclosure of the nature of the disabilities under which he labors.

I have said that for the behaviorist what a person thinks and feels is of no significance and to society what a person thinks and feels matters not at all. It is only what one does that counts. A man may think all he likes of murdering his neighbor and he will never be arrested, but the moment he attempts it the authorities are after him. But psychologically, from the standpoint of the organism as a complex of action systems, thinking and feeling are but acts ***in statu nascendi.*** Many acts never get beyond the thinking and feeling stage, are never translated into conduct, and in connection with every one that is there are certain other, counter assertions, of opposing tendency, which, while they do not gain frank expression, are at least able to modify to some extent those that do. This arrangement by which conduct is the result of choice between opposing tendencies, each of which with varying force tries to avail itself of the machinery of expression, is the plan upon which the organism is built up. The athlete's muscles, if all extended or all flexed, would be useless to him in making those rapid movements upon which his skill depends; the heart, if it were not nicely balanced between an accelerating and an inhibiting mechanism, would be quite unequal to those quick responses, to the demands made upon it upon which life itself at times depends. It is the same with psychological tendencies. Progress is never unimpeded, obstacles always bestrew the path, difficulties must ever be overcome. It is true that the end product, conduct, bespeaks the man, but it is essential, when conduct is inefficient, to know something of the internal obstacles that interfere.

I have said that with every act there is some other, counter assertion that is attempting to appropriate the means of expression. In this highly figurative way I have put the case for what the psychoanalyst calls the wish. All of these tendencies within the psyche which are struggling for expression are wishes in the sense of this school, and it is only by knowing what they are and their relative strength that a dynamic plat, so to speak, can be made of the personality. The wish to conform, to be well thought of by one's fellows, is practically always dominant, but behind each such wish there is another, antisocial, infantile in tendency, that also seeks expression. The first is almost sure to succeed, but the degree of its success is measured by the strength of the second. The soldier who was afraid to go forward was also afraid not to because of the discredit his failure would bring in the opinion of his associates. For the same reason he was afraid to run away. The dread of loss of social esteem was often sufficient to overbalance a fear that was not strong enough to be controlling, and he went forward. But for some the fear of going forward was so great that it was impossible to do so. Equally, death faced them in the form of a firing squad if they ran. The solution was, say, a neurotic paralysis of the legs which so crippled them that they could not walk, much less go forward or run away. The solution of the impasse was illness, but the illness itself was a concession to the social demands. Illness is respectable, cowardice is not. The soldier solved his difficulties in a socially acceptable way, but at the expense of a serious illness, which not only saved him from being shot, but crippled him so effectually that he was not good for much of anything, at least for a long time.

The behavior of our handicapped classes shows, therefore, a great desire for social esteem. The very illness that marks them as outside the crowd takes on a form which at once admits them as members. The necessity to conform is so great that one finds it lacking only in the severest and most malignant forms of mental disease and perhaps not altogether there. In passing, let me suggest that a tendency which manifests itself with such strength and so universally should be a wonderful source of energy for good. Handled with wisdom, it should be a source of tremendous power.

Society, like Procrustes, demands that all shall come up to a given standard. It, too, makes a standard that few can achieve; we are all a little too long or a little too short for the Procrustean bed. But society is relentless and chops us off or stretches us out to fit, regardless of the injury inflicted. Society demands our last measure of adaptive power, and to the extent that we do not fit, to that extent we may compromise by the subterfuge of illness; we may pretend, but in the last analysis we must pay the price, which in the end is death, the final failure.

Now there are two approaches in helping to better inadequate adjustments. You may try to change the individual, as already indicated, or you may try to change the circumstances. The former particularly requires a certain attitude of mind in you which is essential to success. It is the attitude of the scientist. It is impersonal in the sense that it is not fraught with sentimentalism, which is dangerous, or with a sympathy that may be blinding. It requires an understanding based on knowledge and an unqualified desire to bring to pass a better state of affairs, untinctured by self-seeking motives.

In order that I may convince you of the importance of this state of mind, you must know that the antisocial wishes that find expression in conduct are unconscious to their host. Modern psychology has demonstrated that the larger part of our mental life, that portion from which comes all the motive power for conduct, lies beneath the threshold of what we ordinarily call our conscious selves. This is the region in which all that complex battle of motives occurs which ultimately surges to the surface and finds expression in actions of which we are aware. Therefore, blame is an unscientific and useless attitude with which to approach an attempt to effect any change in the results. Our antipathic emotions are only evidences that we ourselves stand in danger of similar lapses and have to bring all our feelings of blame and hate and disgust to bear upon them in order to protect ourselves from seeing in them anything that is desirable. Then again this organ of the unconscious is wonderfully sensitive and is aware, by that subtle process we call intuition, of any unfriendly attitude in those about us. You must therefore learn to purge yourselves of feelings of blame, criticism, disgust, or similar emotions in approaching these problems. The difficulties of adjustment with which you will have to deal can not be helped by approaching them as if they were manifestations of original sin, or by talking down to the unfortunate in terms of specious platitudes. You will have to help to find better solutions than they have been able to, and help, too, in a spirit of understanding, with patience and by means of a superior knowledge. To do less than this is to attempt a correction by the use of undisciplined thinking which will fail at that point where, because of your personal limitations, you are unable to separate the wheat from the chaff. Success, therefore, will come to you in the degree to which you are able to weigh coolly, calmly, and dispassionately all the factors and throw the influence of your knowledge, your training, and your example and character in the balance on the side of better things.

Why, you may ask, should I discuss the attitude of mind with which these social problems should be approached? What can that have to do with the nature of those problems and their solution? Just this: You yourselves are parts of society, you are the instrumentalities through which it is sought to effect better adjustments. Now, just as an instrument must be fabricated for the work it is to do, so you must be shaped for the work you are to do. One would not try to repair a watch with a crowbar or to cut butter with a mallet. You, as instruments of society—as tools if you will—must be forged of good metal, be delicate enough in construction to deal with delicate situations, strong enough where strength is necessary, and keen-edged enough to cut deeply into the facts and discover what lies beneath. This course is the process of your fabrication.

Now with reference to the environment. You must, of course, stand in the community as essentially constructive individuals, but you will constantly come across circumstances in which you will feel convinced that the existing machinery that has been evolved for the purpose of dealing with problems of social maladjustment is inadequate and works hardship and injustice. You should not passively accept this machinery as being perfect, but will be forced to a consideration of how it may be improved. Civilization, our civilization, has come by its traditions and institutions by divers and devious ways. Some of the accepted standards strike very deeply into the nature of man, flesh of his flesh, bone of his bone, but others sit very lightly on the surface. If you will study the construction of primitive society, you will realize that the people we call savages are already at a very high point of social development, that their institutions have a long history and that their organization is very complex. One comes from such a study, which indicates how man has been blindly groping through the ages by a sort of hit-and-miss process, a method of trial and error, wondering whether after all our solutions are necessarily all upon the right track, and inclined to more or less sympathy with a recent writer who closes his book with the following: "To that planless hodgepodge, that thing of shreds and patches called civilization, its historian can no longer yield superstitious reverence. He will realize better than others the obstacles to infusing design into the amorphous product; but in thought at least he will not grovel before it in fatalistic acquiescence, but dream of a rational scheme to supplant the chaotic jumble."

Let me give you an example of how existing machinery creaks in its bearings. A colored boy was incorrigible as a youth. He grew up to adolescence and took to alcohol. He began to be arrested for all sorts of crimes and accumulated a varied and lengthy police record. He served time for petty crimes, for assault, and a long term for burglary. He attempted to kill his wife, and tried to consummate bigamy under a threat to shoot the girl if she refused to marry him. He stabbed one man, acquired the drug habit, and habitually toted a gun when he was drunk and was known as a bad man. He had been passed upon by the local psychiatrist as a psychopathic type of some sort. In other words, he had advertised himself as widely and emphatically as he could as headed for more and increasingly serious acts of a criminal nature. He came and went in and out of jail and prison and finally committed a homicide. Then he was hung. How wasteful and how inefficient and stupid the whole procedure seems in retrospect, and yet that is about the way the machinery works on the average. It is such inadequacies that need correcting, and it is through the careful studies and the accumulated experiences of such work as you are fitting yourselves to perform that more practical methods will be evolved for dealing with the social problems that are presented by such types of individuals.

Human nature has been in process of evolution a very long time. The period covered by history represents only a very short part of the time during which the process has been going forward. The differences between people are very much less than their resemblances, and those differences are in degrees of equipment, which make some a little better able than others to handle their problems. All have at their best something worth while, a percentage, be it ever so small, of efficiency, if only the circumstances are not made too hard. For these problems of society modern psychology, with your help, is to find that adjustment which will most nearly enable people to develop their good points to the uttermost, which will help them to be of the maximum social value within their limitations. Mere repression can solve only part of the problem; beyond that is needed intelligent encouragement and assistance to do better.

And speaking of repression reminds me to say just a word regarding punishment. Punishment is theoretically inflicted as a repressive measure both upon the criminal and by way of example upon those who might become criminals. From this point of view, it is manifestly very largely a failure. It needs to be used after the manner of the conditioned reflex about which the behaviorists write so much. It needs to be scientifically studied, so that it may be used to make the wrong path undesirable, and coupled with an adequate system of training and development, to make the right path more attractive. No one can know the criminal classes without realizing how little they really get out of their way of living that gives satisfaction. But their childish make-up renders that continuity of effort which spells success for most of us impossible for them. They should be assisted to develop this possibility and helped to find activities that are sufficiently interesting to stimulate and maintain it. You should be the clear-minded, disciplined thinkers of the community to whom it will learn to turn for information that will be of service in dealing with all these difficult social problems.

This is the method, you will see, of attempting to make available the energies of the individual to the best advantage. It is quite different from hanging a man because he has stolen two shillings, cutting off his leg because he has a pain in it, or discarding a broken part of a machine and putting nothing in its place. It deals with the human machine and with the social machine as with machines elsewhere—as means of utilizing energy. If a part is not functioning well, we attempt to repair the machine, not destroy it. If the part—the leg, the stomach, the brain, or what not—is out of order, we try to fix it so that it will be as good as new; if this cannot be done, then the next best thing is to try to change the kind of work in such a way that the weakened member will not interfere so much with the results—in a way that will remove the excessive strain from the weak part. If the individual cannot be changed, perhaps the circumstances can.

Let me illustrate more concretely what I mean. The average individual who is seriously defective mentally is to-day practically a total loss to the community. In fact, he is more than just a loss—he is a source of loss in others. He can be rated only as a liability. Now we know, as a matter of fact, that a large number of the feebleminded can be educated and trained within certain limits, are good-natured, industrious, faithful, and reliable—in other words, that they possess qualities that would make them of considerable use if their energies could be consistently directed within their limitations. In fact we all have our limitations and can function to best advantage only when we keep within them. I am convinced that if this principle could be generally accepted, a large proportion of human material which now has to be rated as a total liability could be made an asset, not only from the point of view of society, but from that of the individual himself.

One of my colleagues has suggested that, if large factory owners could be made to understand this, and would provide a special environment for them, a very considerable number of the feebleminded of a factory community could be usefully employed and so kept at home and saved an institutional existence. I am not unmindful of the possibilities for evil in such a scheme. I only point to the possibilities for good.

I was asked to talk to you on the behavioristic attitude—the general approach and fundamental assumptions of modern psychology. I have said a great many things to you in the hour. Let me close by bringing together the main points I have tried to make, by summing up the fundamental assumptions of modern psychology, which it has to offer you on the eve of your entry upon your chosen field of work.

1. The organism is a complex of action patterns.

2. Man *is* what he *does*.

3. Perception, thinking, and feeling are but actions in process of becoming.

4. Action is really reaction in the process of adaptation.

5. The process of adaptation *is* the process of development and evolution.

6. All action implies tendencies and counter tendencies, and what issues depends on their relative strength at the time.

7. Therefore, what a man does he *wishes* to do.

8. The psyche is the head end of the organism and its history is the history of the relations of the organs.

9. The psyche *is* the final grouping of the action patterns, integrated to serve the organism in its functions as a unity.

10. The motives that lead to a-social and antisocial conduct are relatively undeveloped and infantile.

11. These motives lie in the unconscious.

12. Modern psychology places great emphasis upon the unconscious.

13. Society is an organism.

14. Maladjustment is always a psycho-social problem.

15. Its correction may be approached by trying to change either the individual or the environment, or both.

16. Changing the individual requires a knowledge of the internal evidence to elucidate the nature of his personal difficulties.

17. The internal evidence includes the evidence from the unconscious and the evidence from a clinical examination of the bodily organs.

18. Changing the environment is calculated to adjust it to the limits of the individual.

19. The environment includes social institutions that are far from perfect.

20. Repression and elimination are only negative ways of procedure.

21. Punishment needs to be studied scientifically as a means for conditioning conduct.

22. A positive attitude of education and helpfulness is needed in addition.

23. The principle involved is that the individual and society are like machines composed of parts. The attempt should be made to bring the parts into more harmonious mechanistic adjustment to the end of a better utilization of the energy.

24. The problem should be approached in a scientific frame of mind. Sentimentality is and sympathy may be dangerous, antipathic emotions are distorting, understanding and wisdom are essential.

25. You are the trouble men of the social corporation and should be looked to for the clear and disciplined thinking, based on knowledge from your experience, that will be of aid in bringing about better conditions.

A SURVEY OF THE TEACHING OF MENTAL HYGIENE IN THE NORMAL SCHOOLS

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"THE one unthinkable thing in American education is uniformity," said Samuel Thurber some years ago. The characteristic diversity of American education is naturally found in the training schools for teachers as well as in other educational institutions in the United States, although there is a solid nucleus of conventional work in their programs. This diversity extends to the curriculum, the length of the course, and the personnel of the schools. Hence few important quantitative data for statistical study are available, but the qualitative data are significant. The facts in regard to the various schools and the teaching staff are given in the annual bulletin published by the Bureau of Education.[1]

During the last academic year the following questionnaire was sent by the National Committee for Mental Hygiene to the public and private normal and training schools throughout the country:

1. Is any regular course in mental hygiene given in your school? If so, what is the character of the course and how much time is devoted to it?
2. Is any *special* course in mental hygiene given in your school? If so, what is the character of the course and how long a time is devoted to it?
3. Is any part of the field of mental hygiene taught in connection with the courses in psychology? If so, what topics are presented and how much time is devoted to the subject?
4. Is any part of mental hygiene taught in connection with the course in child study in your school? If so, what topics are taken up and how much time is devoted to the subject?
5. Is any part of mental hygiene taught in connection with school hygiene in your school?
6. Is any part of mental hygiene taught in connection with any other courses in your school?
7. Are any courses in practical training of teachers in testing the mental ability of children or in visiting institutions for the

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[1] Educational Directory, 1919-20. Part 3. Washington: Bureau of Education Bulletin, No. 71.

feebleminded and defective or any other form of practical instruction given in your school?

8. Are courses given in your school planned to prepare teachers for ungraded (mentally defective) classes in the public school?

9. Remarks: Any information that you can give in regard to the status of this subject in your school, the books on the subject in your library, the interest of the teachers, or any other matters of importance in regard to the subject.

RESULTS OF THE SURVEY

Replies were received from about 175 normal and training schools in various parts of the country. These schools have an enrollment of over 40,000 normal students, one-fifth of whom are men. The answers are sufficiently numerous and the schools sufficiently representative to render the results thoroughly reliable.

1. As regards the first question, it appears that very few regular courses in the subject of mental hygiene are given in any of the normal or training schools. One hundred and thirty-seven, or 78.09 per cent of all those reporting, state definitely that no courses in this subject are given. A few noteworthy exceptions occur. The following quotations report work done in various schools. In many cases only special phases of the subject are taken up, and yet it is significant that regular courses in mental hygiene are reported.

> W. W. Parsons, Indiana State Normal School, Terre Haute, Indiana: "Yes. Three months on major neuroses and psychoses and various forms of feeblemindedness. These are treated from the point of view of genesis, symtomatology, and treatment, also prevention."

> J. R. Perkins, State Normal School, Danbury, Connecticut: "Defects of hearing, vision, speech, and mentality are considered. The objects of this work are to instruct teachers in what sorts of deficiencies to look for, what signs may indicate these, and what they should do when suspected cases come to their attention. Methods of determining deficiency are discussed, and ways of dealing with such deficient children as must remain in regular classes of normal pupils."

2. To the second question the larger part of the schools — 127, or 72.57 per cent—report that no special courses in mental

hygiene are given. In a few schools, however, special lectures or courses are given. For example, the following:

Hyannis Normal School, Hyannis, Massachusetts: "Five weeks (50 periods) in summer session. Mental measurements."

New Mexico Normal University, East Las Vegas, New Mexico: "A course in mental testing and child welfare. Twenty-four weeks, regular textbook work with experimental exercises."

3. To the third question, the majority of the schools — 103, or 58.86 per cent — report that a part of the field of mental hygiene is taught in connection with courses in psychology. In most cases instruction in regard to very vital topics is given. The following are some of the concrete reports:

Atlanta Normal Training School, Atlanta, Georgia: "We study, as carefully as is possible for us, the different children in our special class from the standpoint of child study. About ten lectures are given each year on such subjects as: Some Causes of Feeblemindedness; The Relation of Physical Health to Mental Health; Different Types of Children to be Found in the Average Grade of a City School; What Should a City Do for its Handicapped Children; A Study of the Jukes and Kallikak Families; What Could a State Do to Reduce Feeblemindedness? These talks are accompanied by assigned readings. We have a *little* literature."

Boston Normal School, Boston, Massachusetts: "Yes. The idea of physical and mental health is considered incidentally throughout the course. In his lectures, the instructor makes use of several of the published articles of Dr. Burnham. Some ten periods of forty minutes each are devoted to the nature and application of general intelligence tests."

Kansas State Normal School, Emporia, Kansas: "A discussion of how to study and of economy in mental work is taken up in Psychology I and II. From three to six recitation hours are given to these topics."

New Mexico Normal University, East Las Vegas, New Mexico: "Yes. An effort to connect the principles of psychology with the personal efficiency of the student is made at all parts of the course of thirty-six weeks in psychology. Such topics as habit, control of attention, etc."

State Normal School, Newark, New Jersey: "The growth of the school compelled me ultimately to concentrate on the department of psychology, but in its application I still treat upon a number of these topics.

> "The integration of the nervous system, the motor character of consciousness (as many as six periods spent on the third paragraph of Chapter XXIII in James' Briefer Course), instinct, emotion, will, the self offer, perhaps, the most obvious suggestions for hygiene. The student is aided in analyzing situations and in making inferences. A few topics taken at random may make clearer the trend of the work:
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> Iterative rhythms, why undesirable; Difference between daydreaming and imagination; Sleep: immediate, healthful modes of securing; Dreams: sex element not brought in, but prophylactic measures suggested; On putting children to bed; Types of play activity."

> State Normal School, Worcester, Massachusetts: "Yes. Among the topics covered in our courses in psychology and child study are the chief instincts, with a discussion of their proper training and guidance; the great human emotions, particularly the fears and phobias, with their roots often if not always in malpractices on the part of parents during childhood; the will and moral development in each of the periods of life—infancy, childhood, and adolescence; improper stimuli and their inevitable consequences in terms of juvenile delinquency; the inevitableness of heredity, with special comparative studies of the chief studies thus far made, such as the Kallikak family, the Jukes, the Edwards-Tuttles, Galton, etc., with emphasis upon the practical conclusions drawn; eugenics and euthenics; plasticity and habit; causes, extent, and disposal of mental defectiveness, with a classification of defectives and a discussion of their relationships with the public schools; a study of the unstable child; physical and emotional characteristics of psychoneuroses and their causes, epilepsy, hysteria, dementia praecox, chorea, habit-spasms, etc."

4. As regards the fourth question, a considerable number — 78 schools, or 44.57 per cent — report that work in mental hygiene is given in connection with the course in child study. In some schools important work is here presented, for example the following:

> Florence State Normal School, Florence, Alabama: "Yes, growth and development; fatigue in learning; maturity, learning and ability; general and special training. We experiment and observe to verify our text. About three months."

> Kansas State Normal School, Emporia, Kansas: "About one-fourth of the time in a two-hour course in child psychology is given to topics in mental hygiene. Backward, superior, and exceptional children are studied; the development of correct moral habits and ideas in early childhood, mental conflicts, control of emotions, etc., are studied."

5. As regards the fifth question, the majority of the schools report that no part of mental hygiene is taught in connection with school hygiene. Sixty-two, or 35.43 per cent, however, report that some part of the field is taught in the school-hygiene course. The following are significant examples:

> Dunn County Training School for Teachers, Menomonie, Wisconsin: "Incidentally. Our teacher gives a course of treatment by lectures to get right thinking on social questions. One lecture a week."

> Huntington College, Marshall, West Virginia: "Yes. Those presented in Terman's *Hygiene of the School Child*. The nervous child; common neuroses of development; the education of the nervous child; speech defects; the sleep of school children; some evil effects of school life."

> State Normal Training School, Willimantic, Connecticut: "Junior class: In planning a hygienic school program those conditions are studied which tend to healthful mental habits, and the reverse are discussed.
>
> "Senior class: Eight class periods devoted to the problems of mental hygiene. Topics in chapters, Terman, *The Hygiene of the School Child*."

6. To the sixth question, the majority of the schools report that no part of mental hygiene is taught in connection with other courses. It does appear, however, that in 41 schools, or 23.43 per cent, some instruction in mental hygiene in connection with other subjects, such as social science, physiology, biology, or the like is given.

> New Mexico Normal University, East Las Vegas, New Mexico: "A special course in psychoanalysis is given, covering twelve weeks' time."

7. As regards the seventh question, 94, or 53.71 per cent, of the schools report that courses in practical training of teachers in testing mental ability and the like are given. The following are illustrations:

> Colorado State Normal School, Gunnison, Colorado: "A course in the measurement of intelligence is given. Students in this course are expected to become familiar with the elementary theory of mental tests and to have practice both in group and in individual methods of testing intelligence."

New Orleans Normal Training School for Teachers, New Orleans, Louisiana: "A course of lectures on testing the intelligence, Binet-Simon tests demonstrated, is given to seniors by psychology teacher. Visits to schoolroom of feebleminded children in graded school. The testing of these children. Also tests of the deaf and dumb classes. A course in educational measurements, description and experiments and explanation of standardized tests in school subjects. Examination of school reports and surveys. Interpretation of these."

State Normal School, Bellingham, Washington: "Mental tests given for purposes of demonstration of children's mental reactions, before classes in child study. Mental tests given to children in training school at request of supervisors. Course in theory and use of mental tests given in summer quarter. Our use of mental tests not with special reference to feebleminded or training of teachers of feebleminded. Show their use in the average school."

State Normal School, Newark, New Jersey: "We take our classes to visit the medical department of the schools when tests of mental ability are given, and also to visit defective classes. And we cause them to make reports on what they there observe."

West Texas State Normal College, Canyon, Texas: "Mental tests and measurements. This course is designed for preparing students to give these tests, such as are standard; accordingly much time is spent in the study of mental tests and their actual application to subjects. In addition, much time is spent in the study of the present movement toward mental measurement as found in school systems and psychological clinics. Some attention is given to such investigations of exceptional children as will assist the student in his grasp of the meaning and significance of the measurement of intelligence. Three term hours."

8. As regards the eighth question, very few schools — only 25, or 14.28 per cent — report any courses especially planned to prepare teachers for ungraded or mentally defective classes in the public schools. The following are concrete reports:

Louisiana State Normal School, Natchitoches, Louisiana: "We have arrangements under way for the establishing of an educational clinic and psychological laboratory. A course in the exceptional child will be offered in the summer session, and regular systematic work along practical lines will be taken up at the beginning of the fall term. Five hundred dollars' worth of apparatus and materials will be installed between now and the opening of the summer term, and several hundred dollars' worth will be added before the opening of the fall term. Our plan is to include a regular series of experiments in connection with Psychology 1 and Psychology 2 and institute special clinical work in the training school, looking forward to the establishing of a special room. This will eventually lead to the training of a few teachers of special ungraded rooms. All the leading books in this field are either now in the library or will be ordered in the near future. Also journals will be included which treat of this special work.''

Newark Normal School of Physical Education and Hygiene, Newark, New Jersey: ''No. We hope at most to make our graduates conscious that if, in their future work, they are appointed to mentally defective classes, they must devote themselves to special study of the question. That is to say, they will not be ignorant of the fact that they are ignorant of the adaptations necessary in their practice.''

State Normal College of the University of Montana, Dillon, Montana: ''Only in a limited degree. A few of our pupil teachers have become successful teachers of such classes.''

State Normal School, Florence, Alabama: ''Yes; for ungraded, but not for 'mentally defective.' Ungraded schools in this country do not mean mentally defective.''

State Normal School, Montclair, New Jersey: ''We train for the public schools. But our students in genetic psychology cover ground that fits them to take special courses at Columbia, New York University, the Vineland Training School, and elsewhere.''

9. To the request for information in regard to the status of mental hygiene, the books used, and the like, many instructive answers were received. The interest in the subject, the desire for help, the attitude of the teachers, the demand for literature, the aim of the instruction, the needs of the normal schools in this field, as well as the difficulties that are met, are well shown by the following citations from the remarks made by various teachers:

City Normal School, Patterson, New Jersey: ''A wide interest in mental intelligence tests—by teachers and students. A great deal of help sought in sifting out special cases. Much individual work given in efforts to restore pupils who have fallen behind, but are *not* defective.''

Jamaica Training School for Teachers, Jamaica, New York: ''Little attention has been given to the subject. The teachers are held pretty strictly to the material in the city course of study for training schools. Any change would have to come from the central authorities. At present the curriculum contains more than can be effectively done by the average student, and the introduction of any work, however desirable, would demand a revision of the course of study, which could be done only by the central authorities. I should be glad to receive any literature on the subject which might aid me not only in understanding more fully the character and extent of the work which might be done, but as aid to at least some incidental work in that line in connection with my regular work in psychology."

Newark Normal School of Physical Education and Hygiene, Newark, New Jersey: "We are interested to know how much time, and to what extent, the Committee for Mental Hygiene would recommend the subject to be taught in a regular physical-training normal school. We will always be ready to further the work of your committee and would be greatly obliged for any literature you might be able to send us in the program you are planning."

State Normal College of the University of Montana, Dillon, Montana: "Outside of Goddard's and a few other books, none in the library; teachers have no special interest in the subject."

State Normal School, Duluth, Minnesota: "So far the attention given the subject generally has been limited to the opportunities afforded in carrying on the regular work. This does not mean that it has had little attention, but rather that it has seemed to be the best way to handle it."

State Normal School, Florence, Alabama: "A number of teachers are much interested and we are planning to use Terman's book next term. Any help will be greatly appreciated."

State Normal School, Gorham, Maine: "Nothing in library except the new works on child psychology such as Norsworthy and Whitley and Waddle. A little special magazine literature. The interest of the teachers in mental tests is exceedingly good."

State Normal School, Keene, New Hampshire: "We wish all the possible help we can get on practical methods and devices for teaching backward and defective children."

State Normal School, Newark, New Jersey: "It consciously underlies all of the work in psychology, one-third of the time, possibly, being devoted to mental dynamics and two-thirds of the time to its efficient direction. Several of the teachers trained in testing and also in handling different types and degrees of defect, with much skill in handling cases of nervous disorder (not insanity). Knowledge of psychoanalysis, but no *training* in its use. The splendid equipment and hearty coöperation of the Newark Public Library have made it unnecessary to have a large collection of the works on this subject.''

State Normal School, Plattsburgh, New York: ''We have a number of well known books of the kind in our library, but none very recent. I am trying to make up a list that will be useful to the teachers and those preparing to teach. Anything technical would not be read. To be of use in our work, such books should consist as far as possible of plain statement (not over-statement) of accepted facts, not long discussions of matters still in dispute.''

State Normal School, Salem, Massachusetts: ''At least we teachers in the training department and the teacher of psychology in the normal department have made some preparation for this work. The library has a fair number of books in this special field.''

State Normal School, Terre Haute, Indiana: ''Outside of the department of psychology not much is done with the subject. The department of psychology would like very much to receive help in organizing a course in this subject. There is no question about the need of it. The source of material is the only drawback.''

The private normal schools reported in the Educational Directory for 1919–1920 are largely schools for the training of teachers in physical education or industrial and agricultural schools. Some significant answers were received from a few of these schools. The following reports are examples:

New Haven Normal School of Gymnastics, New Haven, Connecticut: ''We have no regular or special course in mental hygiene in our school. Our courses in psychology, education, physiology of exercise, and pedagogy of physical education all lay a foundation for right living from the standpoint of mental hygiene, but we do not give any special instruction in that line. Our seniors have some lectures in regard to defective children and have some opportunity for observing the work with defective children in the public schools in New Haven.''

Sargent School for Physical Education, Cambridge, Massachusetts: ''It is essentially the basis of our course on the relationship of mind and body. We feel that our physical work is, by its very nature, the best preparation for a sound mental outlook, and that with this ideal in view, our graduates are well equipped to spread the gospel of mental hygiene.

''The fact that for some years physical exercise has been recognized as an essential factor in awakening the sluggish mind and in

> stimulating the mental powers of defective and deficient children and adults increases our conviction that adequate physical training of the average normal child is one of the best means of putting into practice the theory of mental hygiene."

The general results of this survey may be summarized briefly as follows:

Few schools give any regular courses in mental hygiene.

Few give any special courses in mental hygiene.

Most of the schools have a certain amount of instruction in mental hygiene, often a very important amount, in connection with the work in psychology, child study, child hygiene, or other subjects.

Many schools give a good amount of attention to mental tests.

There is great diversity among the different schools as regards the attention given to the subject of mental hygiene. Some regard it as important and give much time to it; some regard it as important, but give little time; some do not recognize its significance; some apparently have no clear idea what it is; while some aim to give the new conception of health as a mental and moral as well as a physical condition. The amount of time devoted to this subject, even in the best normal schools, is inadequate. The work is usually scattered; the instruction is not always expert; and sometimes the common academic tendency to camouflage the facts is suggested.

Great interest and desire for help in the presentation of this subject are shown by many of the normal schools.

What is needed in many schools is suggested by the work done in the schools that give most attention to the subject.

To a large extent the old idea still prevails that mental hygiene has to do with the abnormal.

Some schools are beginning to see that mental hygiene is quite as important for the normal as for the defective.

THE MOST SIGNIFICANT RESULT

The one significant result of the whole survey, apart from the gratifying interest shown in the subject of mental hygiene, is the fact that what is actually being done in the normal schools gives the best suggestion and emphasis in regard to what could be done in all schools.

If a student could go from one school to another, say to half a dozen different schools where the best work is given, he would get a good course in this subject. If we could put together into one course in one school what is done in a score of the best normal schools in the courses of psychology and child study, we should have an admirable course in mental hygiene. Such a course would be, briefly, somewhat as follows:

Department of Physiology, State Normal School, Ypsilanti, Michigan: "I. Introduction; scope of the subject; references; some examples of emotional states reflected in bodily states.

"II. Internal secretions; general nature, illustrations of their influence; organs of: thyroid, thymus, pituitary, pineal, adrenals, gonads, pancreas. Hormones and chalones. Cannon, Chapters 1 to 8.

"III. The visceral nervous system. Howell.

"IV. The central nervous system. Laboratory study of neurones, cross sections of spinal cord, superficial anatomy of the brain.

"V. Reflexes.

"VI. The functions of the brain. Loeb: Instincts; associative memory, localization. Crile: The relation between the physical state of the brain cells and brain functions. p. 111.

"VII. A mechanistic view of psychology. Crile, p. 127.

"VIII. Phylogenetic associations and the emotions. Crile, p. 55.

"IX. The general laws of heredity.

"X. Neuroses. Freud.

"XI. The teacher and the parent as makers of character. Mental hygiene in the school and the home.

"XII. The relation between religion and bodily condition."

State Normal School, East Stroudsburg, Pennsylvania: "Striking variations of personality and mental hygiene and mental efficiency; variations of personality as related to the nervous system; what is the difficulty in cases of inadequate personality; nervous currents and resistances; neurasthenia and psychasthenia; bodily causes of mental variations; mental causes of mental variations; the subconscious; sleep and dreams; shifting personality; common types of insanity; our attitude toward the peculiar personality; the new ideal in education; rules of physical (bodily) hygiene; rules of mental hygiene; what ails the unhealthy mind? Maladjustment during school days; fatigue, bodily and mental; signs of fatigue and weariness; training for efficiency; principles of mental efficiency; what can the teacher do?

"It is difficult to state exactly the time given to these topics, especially as some of them come up again and again during the course. I try to give them sufficient treatment so the student can make practical application of them."

State Normal School, Terre Haute, Indiana: "Instinct and Development. Proper development or treatment of instinctive tendencies; normal development and growth in contrast with forced, overstimulated, overemotionalized—e. g., fears; Adler's feeling of inferiority; Terman's *Hygiene of the School Child*, chapters on mental hygiene.

"Mental Hygiene of Childhood. The subnormal, the supernormal child, and the nervous child; the fears of children, their genesis and prevention; the establishment of correct reflexes and associations in early childhood; suggestion, its use and abuse.

"Tests of Intelligence. A course in testing mental ability. Students do some actual testing, look up back histories, make special diagnosis of abilities and disabilities, and suggest treatment."

Cleveland School of Education, Cleveland, Ohio: "Principles of Mental Hygiene for Normal Children. The hygienic significance of the mental attitudes. Mental conflicts. Fear in relation to the mental health. Mental conditions in the normal that simulate feeblemindedness."

This course is not the best that could be arranged, but it is a good course and it is entirely a practical one. This is indicated by the fact that the various parts of it have actually been tested in the courses given in various schools. The only question is the question of time, relative value, and the possibility of competent teaching. Is such a course worth while? Is there anything really significant in mental hygiene for the teacher? The returns received give a pretty strong affirmative answer to this question.

The value of such a course in mental hygiene as that outlined above, combining the work done in various schools, is suggested by the following bibliography selected from the books now used in the various schools:

BIBLIOGRAPHY OF REPRESENTATIVE BOOKS NOW USED IN VARIOUS NORMAL SCHOOLS

1. Ayres, L. P. Laggards in Our Schools. New York Charities Pub. Comm., 1909. 236 p.

2. Binet, A. and Simon, H. Les Enfants Anormaux. Paris: Colin, 1907. 211 p.

3. Breckenridge, S. B., and Abbot. The Delinquent Child and the Home. New York Charities Publ. Comm., 1912. 355 p.

4. Burnham, William H. Mental Health for Normal Children. Publication of Massachusetts Society for Mental Hygiene, 1917, 8 p.

5. Burnham, William H. Success and Failure as Conditions of Mental Health. MENTAL HYGIENE, Vol. III, pp. 387-397, July, 1919.

6. Clouston, T. S. The Hygiene of the Mind. London: Methuen, 1906. 284 p.

7. Cornell, W. S. Health and Medical Inspection of School Children. Philadelphia: Davis, 1912. 614 p.

8. Forel, A. H. Hygiene of Nerves and Mind in Health and Disease. New York: Putnam, 1907. 343 p.

9. Goddard, H. H. Feeblemindedness, Its Causes and Consequences. New York: Macmillan, 1914. 499 p.

10. Guthrie, Leonard G. Functional Nervous Disorders in Childhood. London: Frowde, 1907. 300 p.

11. Henderson, C. R. An Introduction to the Study of the Dependent, Defective and Delinquent Classes. Boston: Heath, 1901. 397 p.

12. Hough, T. and Sedgwick, W. T. The Human Mechanism. Boston: Ginn, 1906. 564 p.

13. Mosso, Angelo. Fatigue. New York: Putnam, 1904. 334 p.

14. Offner, M. Mental Fatigue. Baltimore: Warwick and York, 1911. 133 p.

15. Osborne, C. A. The Sleep of Infancy as Related to Physical and Mental Growth. *Pedagogical Seminary*, 1912, p. 1-47.

16. Rachford, B. K. Neurotic Disorders of Childhood. New York: Treat, 1905. 440 p.

17. Sandiford, P. Mental and Physical Life of School Children. New York: Longmans Green, 1913. 346 p.

18. Scripture, E. W. Stuttering and Lisping. New York: Macmillan, 1912. 251 p.

19. Seashore, C. E. Psychology and Daily Life. New York: Appleton, 1913. 226 p.

20. Shuttleworth, G. E. and Potts, W. A. Mentally Deficient Children. London: Lewis, 1919. 236 p.

21. Terman, Lewis M. The Hygiene of the School Child. Boston: Houghton Mifflin, 1916. 362 p.

22. Terman, Lewis M. Measurement of Intelligence. Boston: Houghton Mifflin, 1916. 362 p.

23. Tredgold, A. F. Mental Deficiency. London: Baillière, Tindall and Cox, 1914. 491 p.

24. Wells, F. L. Mental Adjustments. New York: Appleton, 1917. 331 p.

25. White, W. A. Principles of Hental Hygiene. New York: Macmillan, 1917. 323 p.

26. Literature of the National Committee for Mental Hygiene, 50 Union Square, New York City.

27. Literature of the Massachusetts Society for Mental Hygiene, 1132 Kimball Building, Boston, Massachusetts.

Comments and Criticism

The replies to these questions are very illuminating, not merely for the direct answers given, but also as showing the attitude of intelligent people toward the subject of mental hygiene. The strong interest in the subject and the desire to do more in this field as soon as possible are gratifying, and to some will be surprising. Although the work is done chiefly in connection with other subjects, like psychology, child study, and child hygiene, it is recognized as important and evidently makes its appeal to the students.

In some schools, apparently, there is great interest in the subject, work has already been begun, and the aim is to increase the attention given as soon as opportunity offers and suitable literature is available. The following report from one school is a noteworthy illustration of this interest. The work was begun two years ago with tests of accomplishment in subject matter and intelligence tests, according to the Terman revision. The teacher reports that the work has gone far enough so that she can speak in regard to the practical application to school work in the normal schools, and adds, "We are just about to enter upon a more elaborate adaptation of this work to our needs." As regards the aims and methods of the plan, the report is as follows:

> "1. Instructors in methods of teaching subject matter acquaint their students with the accomplishment tests available for their particular subjects.
>
> "2. Supervisors direct the practice teaching in these subjects to test out the progress children are making in subject matter, by the use of the available tests. When these tests are made, the pupil teachers assist and keep permanent records.
>
> "3. The instructor in psychology presents to the students the possibilities of group and of individual mental testing, and gives demonstrations of both. (We give 25 hours to this work.)
>
> "4. The head of the practice school, with the assistance of the grade supervisor of each grade, gives mental surveys of the grades in the practice school, with practice teachers present. (We use the Pintner suggestions.)
>
> "5. The instructor in psychology does individual testing of pupils in the practice school, practice teachers assisting by scoring.
>
> "The teachers who graduate from our school understand the scientific attitude that has come into teaching. They should be able to give group surveys, both in intelligence testing and in testing for accomplishment in subject matter. They know what is meant by the individual testing, but we discourage their attempting it themselves, believing that they have not a sufficient background in psychology or in experience."

All our correspondents, of course, did have a general knowledge of the meaning of mental hygiene and did not show any such gross ignorance as that of some in the community who stumble at the word or identify the subject with dental hygiene. But nevertheless some had a rather vague and uncertain conception of the meaning of the term, including in their answers, perhaps, such topics as heating, lighting, ventilation, and the like, or throwing the questionnaire into the wastebasket because they did not understand what it meant.

There is, however, general recognition of the importance of the subject, although some seem to think that bodily or somatic hygiene is more important, at least as the necessary foundation for mental hygiene. Mr. Kirk, of the Normal School at Kirksville, Missouri, writes as follows:

> "I always encourage neighbors in building a new house, even though some of them begin with the roof and have to hold their houses up with props in order to get foundations under the houses.
>
> "This teachers' college is doing the unusual thing by trying to start some foundations first and building the roof later. We have a department of child hygiene and public health. We recently installed some six thousand dollars' worth of special appliances for testing both children and grown-ups as to eyes, ears, nose, throat, teeth, lungs, nerves, sputum, skeletal conditions, etc.
>
> "We never knew before that good students and good pupils, good grown-ups and good children had such horrible malformations and abnormal growths and defects to hinder their mental development. Wonderful, wonderful are the ways of men, that yet may be devised and utilized for human betterment.
>
> "Of course we shall be obliged to move right on up into the measure inquired about through your questionnaire."

Parenthetically, the writer of this paper may say that many years ago he, too, began with the foundation of ordinary school hygiene and child hygiene, but soon found that one could not go far in the matters of personal and child hygiene without feeling the need of a knowledge of mental hygiene as well as of the ordinary hygienic structure. In other words, it appeared that to study school hygiene at all adequately, it was necessary to study the conditions that favor the healthful development of that part of the child with which the school is especially concerned — namely, the child's brain and the child's mind.

A survey of this kind can hardly fail to give the investigator some insight into the more serious defects of the normal schools as well as their superior features and excellent characteristics. It would be unfair to the normal schools themselves and to those who have contributed so generously to this survey if the writer did not mention these defects of the schools as he sees them. Frankly and briefly, some of the more serious ones are the following:

1. Excellent as the work in hygiene is in many schools, in general there seems to be a failure to realize that health in itself is a supreme good — that the healthful development of children, physical and mental, should take precedence of everything else; that the one great aim of education in the early years, an aim to which everything else should be subordinate and to which everything else must yield, is the development of habits of health, physical and mental. The key to the whole present movement for health education in the schools is to be found in normal-school training; and here in the training and instruction of the school every teacher should be given a clear realization of the great truth put so forcibly many years ago by G. Stanley Hall in the question: "What shall a child give in exchange for his health, or what shall it profit a child if he gain the whole world of knowledge and lose his own health?"

2. The great fundamental defect of all education in this country — the dependence upon instruction and the neglect of training — is naturally found in the normal schools as well as elsewhere. The processes of training are slow and difficult. Instruction, mere talk, is easy and is emphasized everywhere. In all our education we are prone to depend on the easy method of instruction, and we have not time actually to train children. Parents and teachers alike — the better and more intelligent the parent or the teacher, often the worse the fault — do so much for the children that the children have little opportunity to do anything significant for themselves. No responsibility is placed upon them; they are given little chance for initiative and the stimulus of success in their own endeavor. The danger is sometimes the greater and the more subtle with the trained than with the untrained teacher, because the former has learned how to teach, has acquired certain methods, and naturally wishes to exercise that skill. Here is the opportunity for fundamental reform in the

schools; and, if this is to occur, the key to the improvement again is in the normal schools themselves. There is little danger that the young teachers who go out from the normal schools will not do enough in the way of giving instruction. There is great danger that they will do too little in the way of training. Hence in the normal schools the whole emphasis should be on training, and the young teachers should learn concrete ways by which training may be given, and above all should acquire the virtue of self-repression and the spirit of the learner, so that they may repress their tendency to talk, and give opportunity for the children to learn and to do. This opportunity for initiative by the pupil, the opportunity for doing, and the acquisition of habits that come only by training are of fundamental importance to the mental health of the children; and no one is a good teacher who has not acquired the virtues of self-repression and the ability to give training as well as instruction.

3. With the pressure of many subjects, and with the many professional demands upon the normal schools, their limited time, and the defects of preparation in the pupils that come to them, almost inevitably there is a certain lack of pedagogical and hygienic perspective and a tendency to overlook and neglect certain fundamental educational principles in the exigencies of detail in method and grading and concrete instruction.

4. Naturally the normal schools, like all other parts of the educational system, are apt to be unduly bound by convention; subjects are taught because they have been taught, methods are employed because they are traditional, projects and devices are adopted because they are used in other schools. Thus the young candidates go out with a certain conventional professional equipment which has been largely good in the past or may be good to-day in general, but which breaks down in many concrete situations in the schoolroom. What is needed is a better knowledge of elementary psychology and mental hygiene and a better equipment of common sense. This endowment of common sense cannot, of course, be taught, but it is possible to give young teachers a prevision of many pitfalls that will be met in their work and to save them from

making fools of themselves in many practical situations in the classroom.

5. One of the most serious defects likely to be found in normal schools is the failure to emphasize properly the mental and somatic hygiene of the teachers themselves. It seems gratuitous and officious to remind educators that teachers are human, but the need of training in personal hygiene, both physical and mental, is seldom adequately realized, and the personal traits, mental conflicts, and emotional handicaps among these young teachers cannot be properly understood without a knowledge of mental hygiene; one of the greatest needs of the normal schools is to give the teachers themselves the benefit of the fundamental truths of mental hygiene and a training in mental development that will be a safeguard to them in the trying profession for which they are preparing.

THE NEEDS OF THE NORMAL SCHOOLS

That school hygiene, including mental hygiene, lies at the very heart of the essential preparation of teacher and nurse in the normal school is obvious when one reflects that the primary aim of normal-school training is to develop permanent habits of professional interest. As in any other professional school, little can be done in the way of direct practice; most of the work must be in the development of interests that will, as Herbart long ago pointed out, enable the teacher to profit by experience later in the schools. One of these professional interests is the hygienic interest, a preperception of the things that make for the health of children and of the things that are injurious to health, and the realization that the first thing in the training of normal children is the development of habits of health, physical and mental. Of course another great professional interest is the interest in service; and since so large a part of the service that the teacher renders is in safeguarding normal, healthful development, these two great interests are closely connected.

Special aid would be given teachers by a course in mental hygiene. For example, the great bugbear of most teachers is the maintenance of discipline; teachers again and again maintain that they are not troubled by the work of instruction and the drudgery of teaching, but that the one thing that worries them is discipline. Strangely enough the modern doctrines of psychology and mental hygiene have not been applied in any systematic way to this important subject. At the present time, with the knowledge we now have, the whole work of the school, and especially the discipline of the school, should be recast and remodeled from the point of view of training and morale; and the fundamental principles of mental hygiene should be at the foundation of such reform. The work of discipline affords excellent opportunity for healthful mental training.

The immediate practical needs of the normal schools in mental hygiene are, then, briefly as follows:

1. The development in all schools of a permanent interest in this subject and the realization of its importance as already shown in the most progressive schools.

2. Emphasis on this subject, to bring about such a permanent interest, by giving a regular course designated as a course in mental hygiene, based on the work in psychology and hygiene, but devoted to the practical applications of these subjects in the development of mental health habits in normal children.

3. Literature on the subject of mental hygiene more distinctly adapted to the needs of normal-school teachers, giving the fundamental principles and teachings of mental hygiene in clear, definite, and practical terms, and avoiding technicalities and overemphasis of the pathological side.

4. Instruction in regard to the pathological side and the testing of intelligence, for the purpose, not of making the teachers capable of clinical work and the diagnosis of various forms of defect, but rather of giving them prevision for the ordinary defects and abnormalities and an intelligent knowledge of what should be done for different cases and what cases should be referred to experts, as well as a sufficient knowledge of this aspect of mental hygiene to save them from the prevalent error of mistaking the results of physical defect, disease, unfortunate education, and the like for real feeblemindedness or abnormality.

5. A pressing need in many schools seems to be that of greater freedom for the normal-school teachers and the removal of the obstacles to giving proper attention to this sub-

ject in the normal-school curriculum; to this end perhaps the development of a permanent interest in mental hygiene in the central authorities.

6. Opportunity for each normal-school student to consult a psychiatrist or psychologist properly trained in practical mental hygiene in regard to problems of study, the development of personal habits of mental health, the avoidance of mental conflicts, and the prevention of those mental handicaps which come from personal individual fears and anxieties.

The method and plan in this subject must be determined for the present largely by local conditions. In some schools mental hygiene is likely to be taught more in connection with psychology, in others more perhaps in connection with hygiene, as this survey shows is the practice in most schools at the present time. It is, of course, more important that the instruction be given by a competent teacher than that it should be given as a separate course or in connection with psychology or hygiene or child study; but where possible a course devoted definitely to this subject is desirable.

OBJECTIONS

Naturally when the idea prevails in the community that mental hygiene is primarily for those who have no minds, especially for the feebleminded, many teachers do not think of it as concerned especially with the normal. Some of the attitudes shown are the following: that the students are high-school graduates and have studied physiology and naturally hygiene before entering the normal school; that the subject does not concern the particular school in question because only religious subjects, art, or the like are taught; and closely connected with this is the idea that it is a fad and there is no time for it, that the schools have all they can do to turn out good teachers in ordinary school work. But this excuse no longer works in education. Anything whatever can be done in the normal schools to-day; any subject that is necessary can be taught. Our educational standards and ideas of educational value have been so shaken by the war and by conditions since that thoroughgoing changes are possible if they are found necessary. If it is worth while, the best schools seem ready to take the time for it, sacrificing other things for it, if necessary. Mental hygiene so vitally concerns the most important part of the teacher's preparation and the teacher's work that it is one of the things that should come first, among the essentials; and the question in regard to time should be raised in regard to other things, such as some of the work in methods and the like. Simply let a few schools emphasize hygiene by regular courses in it, and soon other schools will be anxious to follow.

Other objections suggested by the answers of my correspondents and by conditions to-day are that there is no suitable literature, and, again, that a course in this field would be largely an experiment. In answer it should be noted that there is now a large amount of important literature and that the books and articles mentioned in these reports give a good bibliography. The introduction of one regular full course, perhaps of two or three hours a week extending through the entire year, devoted to this subject by itself, would be in nearly all schools an experiment; and yet it would be an experiment in the combination of parts that have been tried in many different schools. Hence it would not be a rash experiment.

The most serious objection to such a course as has been suggested is the fact that often it is hard to get suitable teachers. This difficulty, however, is gradually being met, I fancy; in any case the demand is likely to produce the necessary teachers, and usually any well-trained psychologist can prepare himself for teaching the kind of mental hygiene best suited for the normal schools if he will avoid the more technical work in mental testing and in psychiatry — of which probably a relatively small amount should be given in the normal schools — and devote his time to the conditions of healthful mental development and the hygiene of the fundamental mental processes.

An objection will naturally be raised by some as to the importance of mental hygiene by the query whether children were not quite as sensible and normal before so much was being done for them, before we began worrying about their minds and their mental age. Objections of this kind are apt to be raised; and even educators ask: "Is there anything in mental hygiene for the teacher?"

This reminds one of the old question raised some twenty-five or thirty years ago when the study of child hygiene and school hygiene was begun in earnest in this country: "Were not the children of the older generation, when nobody cared for school hygiene, quite as well off, and did they not develop into more rugged men and women than those of to-day?"

Mr. Marble, the able Superintendent of Schools in Worcester, about that period, suggested at a teachers' meeting that what was needed was not so much an adjustable seat and desk as an adjustable boy. Many sympathized with this attitude; and yet, so far as this was meant or taken as a protest against school hygiene, it had no particular significance and was futile. It did have its significant suggestion, however, as to the need of caring for the mind as well as the body.

To-day, when, at least theoretically, the adjustable seat has won its battle, and when in so many ways we are interfering with the spontaneous activities of children, in directing their play, drilling them in habits of health and the like, it is still more important to recognize the need of developing the adjustable boy and girl. And really the great aim of mental hygiene is that of developing the power of adjustment in children, so that they may face difficult situations and adjust to the concrete situations in which they are placed. There is plenty of opportunity for this, however, without making it necessary for them to adjust to unhygienic conditions in the schoolroom.

Of course in one way it is absurd to ask this question in regard to the value of mental hygiene; for sensible parents and wise men everywhere, from Plato down, have recognized that the health of the soul, habits and attitudes of healthful mental activity, are of supreme importance. Nevertheless, very intelligent people to-day do ask it. At first one is amazed; but what is meant, I suppose, is something like this: Is there in mental hygiene something for the teacher that he does not already know, something over and above what he has learned in society and will learn best of all in the practical work of teaching?

The answer is yes, we do know about a few simple things, and they are tremendously important. They are the things that teachers and nurses and parents are especially liable to forget because they are so simple. And some of these it is the function of mental hygiene to make emphatic. Even if many of them have been learned as part of good breeding and folk wisdom, they should be made clear and concrete.

SUGGESTIONS FOR A COURSE

A satisfactory course for normal schools in mental hygiene, at once practical and scientific, must be worked out by extended experiment and study, with the coöperation of teachers and hygienists. Many practical suggestions have already been offered. Others have been made by experts in psychology and hygiene.

The late Dr. James J. Putnam had a strong interest in this problem of mental hygiene in the normal schools, and believed that the best point of departure from which to study the subject, even for a class of teachers, is the practical and personal and social standpoint. Among the problems he would include are the following:

What persons best exemplify high standards of mental hygiene in their behavior?

What nations, communities, or social groups do so?

On the other hand, under what social and personal conditions do unhygienic habits and views of life obtain?

"What relationships exist between abnormalities (so-called) of the unconscious, primitive, elemental tendencies of the mind and the mental health (sense of isolation and inferiority and their a-social and antisocial bearing)? Possibility, nevertheless, of rising above these obstructions and gaining through conscious self-study and careful discipline a new birth of social and religious sort."

Thus Dr. Putnam would begin with the personal experiences of normal-school students and use very largely their own experience of mental conflicts and the like for illustration, and as the basis of much of the instruction and discussion. With this beginning, or whatever other introduction may seem best in a given school, the breadth of the course that should follow is indicated by the results of this survey. And in no subject, perhaps, is it so important to make the work distinctly scientific in its basis and method as in mental hygiene, since so many fads and errors are prevalent in the community and are often emphasized in the newspapers and popular literature.

Normal-school teachers who wish to formulate a course for immediate use can easily do so from the study of the results of this survey together with the outline of a course suggested by Dr. E. Stanley Abbot in a recent number of MENTAL HYGIENE.[1]

It is especially desirable that the societies for mental hygiene and the normal schools should coöperate in improving the instruction and training in mental hygiene. For a number of years the Massachusetts Society for Mental Hygiene has received requests from teachers and has given them aid in the way of literature, lectures, and the like. Among the more progressive teachers there is a growing demand for help in this field.

The results of this survey are perhaps primarily of most interest and significance for the normal schools themselves; on the other hand important suggestions for the work of the mental-hygiene societies are not far to seek. Most important of all, perhaps, it is clear that if adequate attention is to be given to mental hygiene in the public schools, it must be brought about, not by outside agencies, but by instruction and training in the professional schools themselves.

SUMMARY

After this survey we are in a position to define at least tentatively the term mental hygiene as it is understood to-day by teachers and psychiatrists alike. To put the whole matter in a single sentence, we may say that mental hygiene has to do not only with the care of the mind diseased, but with the prevention of mental disorder and the development of habits of mental health.

Our survey has at least shown something of the scope and the significance of mental hygiene for the teacher.

It has shown what the normal schools are actually doing in this subject, and the literature used.

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[1] See *Program for Mental Hygiene in the Public Schools.* By E. Stanley Abbot. MENTAL HYGIENE, Vol. IV, pp. 320-330, April, 1920.

It has shown what might well be given in any normal school, and what will be given in good normal schools in a few years.

It has suggested the extent of the course in mental hygiene needed by all teachers.

Naturally a plan like this is apt to be called Utopian. This, however, is in its favor rather than against it. A large part of the things in ordinary school hygiene and child hygiene were Utopian when first advocated. The physical examination of school children, school baths, adjustable furniture, scientific cleanliness twenty-five or thirty years ago were merely the vagaries of scientific theorists. Now they are well-established facts in the best schools. Utopia, as Dr. Richardson used to say, is merely another name for time.

The main points in regard to the aim and significance of mental hygiene in schools for the training of teachers can be summarized briefly as follows:

1. The aim of a course in mental hygiene for teachers should be to develop an interest in the subject, so that teachers may understand the literature and recognize the significance of mental hygiene. Such an interest can be aroused by presenting the facts, and best of all by clinical observation of children, personal training in mental hygiene, and the development of habits of healthful mental activity in the teacher's own life.

2. As a result of the development of an interest in mental hygiene, the teacher should get a knowledge helpful in personal experience and behavior. Such an interest can be developed and such a personal application aided by the study of one's own mental habits, interests and attitudes, and mental conflicts. Instruction in mental hygiene will naturally lead teachers to apply its principles to themselves; and nothing would so improve the personnel of the teaching profession as the development of mental health, enabling the teachers to set an example of poise, of sanity, and of morale in the schools.

3. The general principles of mental hygiene give teachers a prevision for habits of mental health and for mental defects in their children. The difficulty is apt to be that they make snap judgments and sometimes think children that are feeble-

minded are normal, and on the other hand that normal children who have been handicapped in certain ways are feebleminded. A study of mental hygiene shows teachers the complexity of the whole matter of determining the mental condition of children and the need of referring cases that require diagnosis to competent psychiatrists.

4. A good course in mental hygiene will naturally show teachers the real aim of school training and school discipline — that it is not the correction of individual faults, but rather the development of morale, habits of healthful mental activity, self-control, and the ability to put forth effort and to face difficult situations.

5. A course in mental hygiene will naturally fit teachers to perform their social function in the community the better. Every teacher should be allied with the progressive forces in social evolution, and no one without proper training in habits of healthful mental activity can perform properly these social duties.

6. Again, teachers need extended training in mental hygiene in order to avoid the pitfalls to sound reasoning and sanity of mind that beset all human beings. These are all the sources of error noted so forcibly by Roger Bacon; the idols of the tribe, of the den, and the like, described later by Francis Bacon; and the faults of teachers observed by wise men in the profession ever since that time.

In the teaching profession more than in any other, perhaps, good judgment, sound common sense, balance, self-control, freedom from prejudice, and the scientific attitude of mind are fundamentally important. The importance of this is not limited to scholarship and teaching and reasoning, but really is a matter of significance for hygiene, because only those who have a keen sense of reality, only those who are willing to face reality, and who have acquired the habit of constantly correcting their reasoning by reference to reality, are likely to have that anchor of steadfastness and clearness essential for mental health.

7. Many things are involved in the teaching of hygiene, and it is especially important that the movement for practical hygiene should be furthered. It offers one of the greatest opportunities for social service in modern life. The oppor-

tunity in mental hygiene is as great as in general hygiene. Only by scientific courses in the professional schools can due attention be given to the subject.

Again, to put the whole matter in a single paragraph: The introduction of suitable courses in mental hygiene in the normal schools represents a movement of first-rate importance. Few realize the significance of this subject for teachers. The teacher and school nurse need this training in the first place for their own mental health and efficiency. They need it again in order to recognize those children that are permanently retarded or feebleminded and that should be referred to expert physicians. They need it to do justice to the children handicapped by defect or unfortunate early training. They need it, in fact, in order to do their duty to all the normal children. It is necessary also in order to help the teacher in the problem of discipline and in maintaining the morale of the class. The nurse needs the help of mental hygiene so that she can give the proper advice and encouragement to the mothers who come to her with the pathetic stories of their own children. It is necessary, finally, for the teacher and nurse that they may share in the social service of the community, in all of the many movements for human betterment.

MENTAL HYGIENE AND THE PARASITE

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IT is the purpose of this paper to present an outline study of two types of human nature, the *parasite* and its *host;* to trace the development of these types back to their sources in the mind life of the child as this mind life has been formed and fashioned by the childish reactions to its environment and training; and to offer some constructive suggestions as to how parents and teachers should deal with the child mind in order to prevent the development of these two common types, from which come so serious a percentage of adult failures in adjustment, of adult mental and physical pathological conditions, and hence so large a percentage of social and economic wastes.

For, while mental hygiene and "mental medicine"—or psychological measures taken to correct and remove the psychological causes of pathological conditions—are of inestimable service, once the pathological symptoms have become established or the failures in adjustment have begun to take so serious and evident a form as to demand attention, nevertheless, the most salutary service that mental hygiene has to offer and the most far-reaching results that it is privileged to bring to pass must be in the way of prevention, in the way of discovering and effectively dealing with the psychological pre-conditions and causes of the development of what we later designate as adjustment failures or as pathological conditions, according as the outcome is an actual breakdown in health of mind or health of body or is failure in making personal and social adjustments, failure in finding a happy, contented, and constructive place in the social fabric.

These failures in adjustment, to be intelligently understood, must be traced back in their origin to the way in which the web of life is spun in childhood and infancy. We have too long looked upon them either as growing out of the immediate situation wherein they first manifest themselves in so obvious a form as to demand attention, or else as due to hereditary conditions over which we have no control. The fact is that, by this attention to the immediate situation and this appeal to hereditary determiners of conduct, we have been prevented from seeing what we can do with the material that nature has furnished us, and from tracing to their sources, in the training of the individual during infancy and childhood, those characteristics of the personality which later cause these failures in adjustment.

In looking into the psychological causes that operate in infancy and early childhood to bring to pass the later delinquencies, failures, and pathological conditions, we need summon to our aid no abstract conceptions of *élan vital,* libido, or any other sort of peculiar psychic entity, by whatsoever name it may suit us to call it. We have only to look to the concrete ways in which the child is made to feel, to think, and to react in the everyday affairs of his childish life, in the common experiences, rather than in the startling or shocking or uncommon incidents, though the latter do in some cases have their part to play. Such experiences are, however, comparatively rare, while the everyday experiences of the child are the real factors that almost universally determine the outcome in later years, and to these we must look for an explanation of the maladjustments and the symptomatic conditions of the adolescent and adult.

Mental hygiene must begin with the very first days of the infant's life, for only as, throughout the years of infancy and early childhood, those precautions are taken and those measures are observed which make for healthy-mindedness in its most fundamental and significant sense will we be able to make any appreciable headway against the ever-increasing crop of adult failures, mediocre attainment, delinquency and irresponsibility, and the various kinds of mental and physical diseases that grow out of psychological conditions and causes. Nor need we be baffled by any sort of abstract idea about what constitutes the essentials of an environment that makes for mental health. The orderly, obedient, controlled, well-poised nature—the nature that is able to face reality with upstanding courage instead of turning from reality to live a life of phantasy, the nature that does not shrink from the world of facts with timidity and a craving for a soft place and a pleasant berth, that is able to take criticism and direction, that controls feeling by intelligence, standing foursquare to every wind that blows—this sort of nature must be provided for in the infant days, and its foundations laid by the very atmosphere that surrounds the child. And this atmosphere is no subtle, indefinable, and vague abstraction; it is the sum total of the habits of ongoing in the hourly care of and association with the child, in the manner of his being handled and dressed and fed and bathed, in the attitudes of his elders in every matter that may come up in his presence, in their moods as they are about him, in their own ways of meeting every incident in life, be it great or small. Too much emphasis cannot be laid upon the fact that it is out of the commonplace, everyday, matter-of-fact experiences of the child that come the various characteristics that form his personality and that determine the nature of its expression in later years. The world of parents and teachers needs to learn this lesson above all others—that nothing dare be considered of no moment in the life of the child merely because to the adult it is of no special interest or importance, or merely because it is the experience of a child and therefore cannot be of any great significance. We must never forget that it is from *his own* reactions to *his own* experiences that he is getting his bent; out of the myriad small happenings of his daily life is being formed that great dynamic source of motivation, the unconscious, which will ever wield so powerful an influence throughout his later life for good or for ill in determining his choices, tastes, judgments, and reactions. Moreover, the adult needs to keep this fact ever before him—that the child is having his nature formed for the most part without any understanding, in the adult sense of the term, of what is so forming it. Great harm is frequently done through failure to realize that for a child to be molded and fashioned by a given experience or situation, it is not necessary for him to have any rational, clearly conscious, and definitely ideational understanding or conception of any of the elements in the situation to which he is reacting. Neither can adults be the arbiters as to just what aspects or phases or elements of a given situation the childish nature is going to react to, or will be bent on absorbing.

How often, for example, do parents permit a small child to be present when gossip is being whispered, or when grave affairs are being discussed or affairs that are decidedly not for childish ears, under the mistaken impression that, because the child cannot understand the meanings, intellectually, of the words and situations, of the circumstances and the events, these are therefore passing entirely over his head and hence that he is not being affected thereby. Childish nervous systems are more bundles of feeling-response machinery than of idea-response machinery. The sneer, the jeer, the solemnity, the anxiety, the indifference, the insincerity do not have to be understood as such, nor their causes, real or imagined, grasped by the child, in order to take effect in him, any more than it is needful for him to understand the nature of the physical calamity that would befall him, or the nature of the physical force that would produce the calamity, should lightning strike him, in order to have fear of lightning engendered in him. All that is needed is that the attitude of fear when the lightning flashes shall be taken in his presence by others, and he has been helped by that much one full step toward the same sort of fear reaction himself in response to the sensory stimulus of the lightning flash. Let a person be treated never so politely in words, but with a lack of sincerity, the presence of positive, though highly-cultured frigidity, before the child, and the seeds of hostility and dislike have been sowed in the child's nature toward this person, for his reactions are to the feeling attitudes expressed, rather than to the words that belie the attitude. Let the attitude of parents and adult members of the family toward their daily occupations at home or in office be that of dread, or boredom, of dislike or contempt, let real joy and spontaneity of manner and lightness of heart appear only when the holiday, the rest hour, the game, or the diversion are being spoken of or experienced, and the child begins the formation in his nature of attitudes toward work that must be utterly eradicated later if he is ever to find himself in his work as an adult, if he is ever to make his work, whatsoever it may happen to be, that in which his nature finds nourishment and contentment and satisfying expression. And when mother or father finds the growing boy or girl avoiding work, hating to do the errands and take any of the small responsibilities about the home, they are all too prone to lay this to "natural" laziness in human nature, instead of realiz-

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ing that they are reaping what they in large measure unwittingly sowed in his nature by their own daily feeling reactions to their duties and occupations, their cares and responsibilities. Healthy-mindedness toward work and toward responsibility must be engendered and fostered in the child's nature in exactly the same way in which reverence and courtesy are engendered and fostered—namely, by the attitudes of the adults who have the child in their charge.

As a further illustration of the fact that children develop unhealthy attitudes of mind in the earliest years, and long before they have any intellectual comprehension of the situations to which they are reacting, the writer would cite the case of a little boy of six, with whom corrective work has recently been done. The little fellow, by the time he was four years of age, had become completely unmanageable. Much of the difficulty was caused by this very course of procedure—of trusting to the notion that because the child could not understand, intellectually, what was being said or what was going on in his presence, he was therefore not being affected by it. And as he came to be old enough to be able to understand, he had already formed such deep-seated and injurious habits of response that the parents were unable to do anything with him. Not only had they foolishly permitted themselves to discuss whatever they pleased in his presence, but he had been allowed from the time he could walk to toddle to answer the doorbell with his mother, and to be about, listening, whenever father or mother would be talking with callers on no matter what errand, instead of being taught to keep on about his play, attend to his own little affairs, and keep his distance. Undoubtedly he was too young, at the first or even later, to understand what was being said, at least as the adult understands it. But he was not too little to be absorbing emotional attitudes, nor was he too little to be forming the habit of not minding his own affairs whenever there was a conference going on between adults. He was not too little to be having his curiosity stimulated and fed until he had become a sophisticated little eavesdropper. When he was questioned about it—as to why it was he always stood around listening to things that were none of his affairs—he in his childish way made it clear that it was not because he understood very well what was being talked about that he found these conferences interesting, but it was the emotional satisfaction he got out of the attitudes and moods and the general air of "something important going on." He had become a regular little "Paul Pry," and at six years of age would sneak up or slip about anywhere only so that he might be near when adults were talking, enjoying what ideas he could understand and getting immense satisfaction out of the purely feeling side of the situation. So deeply has this sort of response been built into him that after a year of the most arduous and continuous labor with him, though great progress has been made, the boy still needs the greatest care and watchfulness in this regard, before he shall have had this most unhygienic insatiable curiosity corrected in him; a curiosity that, both in its nature and in the form of its expression, will inevitably, unless permanently eradicated, lead him to serious failures in adjustment later and to many a sad and painful experience.

It is of course true that modes of procedure which would form serious habits with one child might not have serious effects upon another, just as methods of training that will succeed with one may not be at all suited to another. The psychology of individual differences that has received so much emphasis during the past twenty years has brought to light the existence of great variations between individuals, as regards their intelligence chiefly. This study of differences in individual intelligence has brought to pass a most timely movement toward suiting our method and content in education more nearly to the intellectual characteristics of the individual child. It needs to be emphasized that even more subtle and significant differences are to be found in the emotional natures of children, and upon these differences in the emotional constitution must rest the differences in modes of procedure in mental hygiene; that is, the training of children must be suited, not only to differences in intelligence, but also, even more, to differences in the modes of emotional response, the tendencies to emotional expression, peculiar to each individual child, if healthy-mindedness is to be developed.

There are, of course, general rules of procedure that make for the best hygienic conditions surrounding the child, but it must ever be borne in mind that no cut-and-dried, rigid methods of procedure can be indifferently applied to each and every child. The concrete way in which a principle of training is to be applied must always be determined by a study of the characteristics of the child who is being trained. One of the commonest of unintelligent remarks that one hears from distracted parents is: "I cannot understand why this child should behave as he does, as I have given him exactly the same training and treatment as the others." And frequently right in that very fact lies the reason for the child's failure to be what the parent has fondly tried to make him by methods that were unsuited to his particular type of nature.

Again, when it is found that bad habits have been formed and that undesirable tendencies are finding expression, another convenient and often used defense by which parents blind themselves to the actual facts and seek an excuse for failing to study and deal with the child according to its own peculiar needs is to appeal to the well-worn phrase: "Oh, just give him time and he'll outgrow it. All children have to go through this sort of thing. He'll come out all right in the end." The support for this destructive and paralyzing creed is found in three all-too-common fallacies. First, there is the very common fallacy of noting only the positive instances in which children either actually or apparently do "outgrow" their bad habits, and failing to note the more numerous negative instances in which they do not. Second, there is the error of supposing that "time" or some other unanalyzable force or cause is that which works changes in individual character and can be counted upon to bring the desired characteristics forth in the personality if only we will have the patience to let it, though doing nothing concrete ourselves to mold and fashion the child nature. If the changes actually do take place, they are the results of the child's having met with concrete experiences that have put a stop to the harmful habits and the injurious attitudes of mind before they have become so ingrained as to be unalterable without the special technique of the analyst. But far more frequently there is the third fallacy—that of taking the superficial appearance for reality, in that the changes seen are purely specious, the inner motivation having changed not at all. It is only that the form of expression has changed in such a way as to hide its source and conceal its true nature. Many a child, for example, has "outgrown" flagrant and open deceit and petty pilfering only to practice the more subtle forms of deceit upon his associates and to follow "honesty" as the "best policy." In such cases there is no genuine honesty of nature being expressed, but only the deepest sort of dishonesty of nature finding outlet in every form of rationalization, every sort of casuistry, every sort of subtle excusing and defending of wrongdoing, which ever keeps within the law, ever uses good manners and acceptable social customs for realizing the satisfactions of a nature that is at bottom thoroughly unsocial, thoroughly self-centered, concealing itself under this mask of pretense of the genuine.

While, then, we recognize that there are natures that may be subjected to wholly undesirable childhood experiences with perhaps a negligible amount of harm being done them, and that there are others that, by reason of later experiences, actually do cast off undesirable characteristics and take on desirable habits and attitudes of mind, nevertheless, these natures can by no means be used to prove the fallacious rule that "the child will outgrow it." There are very strong probabilities against any such "outgrowing," and what is taken for outgrowing is far more frequently an ingrowing in which the results of the experiences have sunk deeply into the unconscious, there to function in so thoroughly rationalized a manner as to be hidden as to their source and nature both from the individual himself, as he comes to maturity, and from all but the keenest students of the back-lying causes of human behavior.

There is special need, then, that we make a study of the nature of the individual child, to the end that his training may be suited to the characteristics that are peculiar to him, at the same time that we hold fast to the application of methods and principles that must never be violated with regard to any child. For example, it is true in general that children need to be fondled and petted and "loved." But there is most serious need to study each child from the angle of the psychological effect upon it of parental petting, cuddling, and fondling. These purely physiological expressions of parental affection should be wholly governed by consideration for the child's welfare rather than by the blind impulse to satisfy the parents' instinctive desire to fondle and hover over their offspring. Just how much of this petting and fondling is good for the child depends in part upon the child's own individual nature and upon the manner of response produced in him by these expressions of affection and tenderness, and in part upon the attitude of the parent who is handling the child; for often such petting and fondling as a child should rightfully receive is rendered unwholesome for it by the attitude of the adult who is doing it. The child is ill, for example, and must needs be taken up and held to rest it from long hours in its bed and to give it tender comfort. If this is done by the parent in an attitude of fear and nervous anxiety for the child, instead of with healthy and wholesome quietness, with confidence and assurance of manner, then a positive injury is done thereby to the child, because of the reactions upon it of this attitude of anxiety and fear. Physicians are all too well acquainted with the fact that the parent is often quite the wrong person to handle the sick child just because of this thing, and a child in a serious condition often begins to recover only when the frightened and anxious parent is persuaded to leave these tender ministrations to the cool, confident, well-poised nurse. In the case of a serious illness it is easy to see this principle. But it holds good at all times that whether or not the fondling and petting so dear to child and to parent is wholesome for the child will depend in large measure upon the attitude of the parent, as well as upon the nature of the child.

There are children in whom these natural instinctive expressions of parental affection develop a harmful appetite for coddling and prevent the development of a sturdy and healthful independence. This prepares the way for the nature of such a child to turn away from reality as he comes to adult years and constantly to seek for palliation, for sops to the feelings, for soft and pleasant treatment at any price. Such a procedure thus starts the child well on his way towards becoming the host for parasites in later years. In children of still different natures there may be developed by apparently innocent and natural petting and fondling a harmful sex consciousness or harmful "infantile fixations," and, finally, injurious sex perversions. And we may by no means assert that because some children apparently survive indiscriminate and uncontrolled fondling, without obvious catastrophe, they therefore have had no real damage done them thereby, for the results may show themselves, and often do show themselves, in devious and hidden ways in the motivation of the individual in his adult years.

There are children who, because of their natural reactions out of hereditary tendencies, call forth from the parents just the sort of treatment that will be their ruin. Too often do we see a fond parent, because of the natural brightness and strong initiative of the child, pushing him on to an overuse of his energies, stimulating him to "show off," developing thereby in the child just those forms of self-projection that will cause his undoing in later years. The child is eager to be seen and heard and shows increasing evidence of ability to do things beyond his years, and the parent, who in turn desires to be seen and heard through the credit and attention that so bright a child will bring him, urges him on. Where only the most insistent care and effort will suffice to prevent one child from overdoing and coming to fatigue, as well as to a blasé attitude of mind, through experiences flooded upon him beyond his capacity to make healthful adjustments to them, in another child only the most persistent care in the very opposite direction will prevent it from becoming idle and shiftless, a useless and destructive parasite upon some unfortunate individual and upon society throughout the days of its life. Over and over again do we see this untoward situation of the child calling forth from the parent the very opposite type of reaction from that which it should receive. The active child tends to call forth overstimulating treatment from the parent. On the other hand, the lethargic, inactive child, who lops and leans and wants always to be held or to sit about, who constantly seeks to get parents to do things for it instead of seeking to do them for itself, tends to call forth from the parent treatment that fixes this sort of reaction in his nature. The parent all too often with such a child responds to its inactivity by making a toy of it, by constantly remarking in its presence, as if this were something to be proud of, that it is lazy and inactive and always making the parent do things for it that it should do for itself, and suiting the action to the word by giving in to the child's teasing instead of stimulating it to be active and to do for itself. By this form of procedure, the nature that needs to be denied coddling, that needs to be encouraged in every way to make effort if the necessary inhibitions and habits are to be established that will prevent the child from becoming a parasite, is helped, instead, to bud and flower and grow after its kind, according to its hereditary bent. Specific study of just such a nature, in its beginnings and its adult outcome, is presented later in these pages.

Thus, through lack of understanding of the child nature, through failure to realize how serious are the results in the characteristics of the personality that are being developed and fostered by their manner of dealing with the child, and through lack of understanding and controlling of their own tendencies to instinctive emotional response to the child, parents and adults who have any dealings with it start the parasite well on its way before school age has been reached.

The term parasite is used here to designate a particular type of nature, rather than to cover all those persons who may be failing to make their proper contribution to social values, who are more or less being carried along by society without themselves rendering adequate return for value received. These latter, while parasitic in many ways in so far as failure to produce or to contribute is concerned, differ from the parasite proper in this, that this failure to make contribution is not due to the development of inherent parasite qualities, but to the fact that such persons have not learned the way of life of the contributor to social values. There has been a misdirection or perversion of qualities, which, had society and environment furnished the right sort of training and opportunity and incentive, would have been directed into truly constructive channels. The qualities that would make them producers are there, and when they are thrown upon their own resources or placed where there is appeal to these qualities and where responsibility comes to rest upon them, they at once make some response, begin to make some effort, seek to make some return and some contribution. Under the same circumstances, the genuine parasite seeks by every means to avoid responsibility, runs to cover, throws the burden upon others, makes appearance of being willing to carry the responsibility or engage in the work, but always does whatever it does in such a way that it gets excused, having succeeded in duping its host into believing it physically unable to do the work, or else makes a great show of really doing the work, but always by subtle craft does it in such a way as to make it necessary for some one else to come in and carry the responsibility, lift the load, do the work. Who has not seen the beginning of this sort of thing with some child who, when asked by the parent to perform some simple household task, would so slight and bungle it that the tired or impatient, and certainly unwise, parent, goaded by the necessity of having the thing done right or by the wastefulness of the outcome if it is left to the child's bungling, dismisses the child with the declaration that she will do the work herself rather than see things spoiled, or even excuses the child with playful remarks on its awkwardness or mollifying comments on its inadequate strength? With children of a certain nature, this is the first step toward performing things that they want to get out of in such a way that some one else will be forced thereby into helping them or into doing the things for them. Then, as soon as the parasitic child has learned, too, that a show of willingness and a pretense of doing the very best it can will get it excused from work and at the same time get it credited as highly as if it had actually done the work, it has been provided with one of the chief methods of procedure whereby the parasite seeks to get itself accepted, to thrust responsibility upon others and at the same time to get credit for "doing all it is able to do."

The parasite always works by this method of sham and pretense and false promises, ever putting up a profession of willingness to make contributions, but never carrying this profession out in reality; ever taking all it can secure of support, position, credit and admiration, adulation and praise, and giving nothing but empty husks to its dupe or host in return. The parasite ever seeks to get itself accepted and to be in favor by making the appearance of following the rules and conventions and chiming in with the tastes of the set or circle of society in which it happens to be moving, ever putting up the pretense of coöperation, of agreement, of willingness to oblige, and ever offering some sort of plausible excuse for its failure to show concrete results.

The host or dupe of the parasite is always one of those unfortunate individuals who by training has not been taught how to face reality, how to distinguish the spurious from the genuine, and whose tendencies in this regard are due primarily to the way in which his emotional nature has been improperly organized and directed in the growing years. These characteristics have their inherent basis, it is true, but they have been formed and fashioned into motivating complexes by the way in which the child has been taught to react to his everyday experiences, particularly in the infant and pre-school years.

The child who is most easily shunted off from facing reality, who is most likely to be given such a bent as to cause him to be deceived and allured by the specious attractions and offerings of the parasitic nature, is usually one of strong and unstable emotional nature. He is a child of unusual capacity and sensitiveness of feeling, which, if properly understood and directed and made use of, would furnish splendid driving power for constructive, courageous, upstanding procedure throughout his life. But unless this deep and sensitive feeling life of his is understood, it may come to generate the deepest sort of rebellion against control and direction and to develop a subtle sense of personal injustice, and to move the individual ever to turn away from those who seek to save him from himself, who seek to teach him robustness and honesty and straightforwardness and self-control, and turn him toward those who make their specious and destructive offers of sympathy, of softness, of understanding, or who appeal to his various appetites, holding out promise of satisfactions which he has failed to receive in other directions. The beginning of this sort of thing is all too frequently in the earliest infant months, in which there is constant response by one parent or the other to outbursts of infant crying and infant temper, a constant attempt to pacify, to quiet by whatever means suggest themselves, particularly by offering food or something to hold in the mouth, and by unrestrained and unwise petting and attention, all accompanied by a weak sentimentality of feeling instead of by firm, quiet, healthy attitudes of mind that would tend to accustom the child to something besides a complete pandering to his emotional explosions. The youngest infant quickly has its nervous system and its feeling life organized and differentiated by this sort of thing into a tendency to be rebellious against any control, into a tendency to seek through "tantrums" the satisfactions of its physical wants.

A child must have warmth and strength and loving, tender care; a child must have brooding and petting and all healthy and healthful show of affection from those who are caring for it. But parents need very much to learn the difference between genuine, healthful, and helpful sympathy and tenderness and the destructive, unintelligent sort so often displayed. True mother love and true tenderness are not the mere instinctive expression and satisfaction of feelings aroused in the mother by the infant's plaints, but these feelings guided entirely by an intelligent understanding of what is best for the little life, both at the time and in its future development. To run and pick up the baby and offer food and coddling in response to its every complaint may be of intense momentary satisfaction to the ignorant and overindulgent parent, but it is very harmful to the best interests of any child, and results later in untold suffering for both child and parent and for all those interested in the child's welfare. Such treatment brings forth its inevitable fruit in the growing loss of control of the child, in the delinquencies that come through his later inability to control or understand himself or to take any vigorous and straightforward criticism and direction, and in his tendency, in every situation where his feelings are aroused and hurt, to be unable to control them, unwilling to get hold of himself, but ever eager to turn to whatever offers his feelings the coddling or the satisfactions similar to those he became accustomed to in what seemed to the parents to be the perfectly proper and harmless—yes, even necessary and helpful, natural and praiseworthy—expressions of parental feeling and parental tenderness for him.

A still more injurious situation develops in those all too frequent instances of disagreement between the parents or the adults who have the care of the child. When mother sees that baby must not be fed because it has awakened too soon and that this great outcry of his must not be responded to, but must be made to abate by a firm, gentle, and insistent refusal to mollify or pacify, that the regular order of feeding must be ahered to, then father or grandmother or aunty or neighbor comes in with just the very show of sympathy which acts as a balm to little wounded feelings and as a rebuke or an opposition to the procedure of the mother. And thereafter baby knows that mother is the person from whom he cannot get satisfactions, while father or grandmother or aunty or neighbor can be depended upon to humor him, and to them he turns, away from the very sort of treatment that will save him from being spoiled and finally from becoming, in later adult life, the prey of any one who comes in when he is seeking to get his own way, to avoid control or direction, looking for sympathy instead of facing his facts and dealing with them. Thus is formed the habit in the nature of ever seeking a solace to the feelings, ever seeking the company of those who offer satisfaction to appetite, to pride, to desire for softness and pleasantness, and no tendencies are formed in the nature to find satisfaction and comfort and companionship with those healthy natures who would give honest criticism, who demand a strict accounting, who are direct and straightforward and frank and courageous and thus genuinely and truly kind. The pampering and misdirection and perversions of the feelings begin with the infant. If indulged by the parents, then, when the child meets with those who will not allow him to have his own wilful way, he turns from them to his parents for sympathy and support, and gets it. He will not face the criticisms and rebukes, the insistence upon obedience, of his teachers, but brings home tales of being abused or treated unfairly, and the fond and foolish parents take his part and continue to fasten upon him this habit of turning away from facing the actual facts of his conduct, from forming habits of life that will stand him in good stead in the face of the world of real things which he must meet. And then they wonder why he has chosen a weak, unstable, parasitic companion for life when they later find him married to a woman who will make no effort to carry any responsibility, who has nothing in her that any healthy-minded person should desire her, but who always keeps up the appearance of soft and winsome ways, and is plainly robbing their son of his very life while he is in the act of turning to her for the softness, coddling and the sop to his feelings which he has come to demand as the result of his misguided childhood training.

The persistent and united campaign of parents ever to prevent the child from facing his little problems with honest courage and sturdy, straightforward acceptance of the consequences of his mistakes or accidents or misbehavior, by always offering him sops for his feelings, always excusing his failures instead of encouraging him to acknowledge and correct his faults and take heed from what he has suffered to avoid similar things in the future—this sort of procedure, while common, is not perhaps as common as the situation in which, after discipline is meted out, the child finds some softness or palliation in his offense in some other adult member of the family or in some friend or neighbor who, instead of helping him by no show of false sympathy, takes his part, either openly or covertly in the numerous ways in which it is possible to get it across to the child that mother or father or teacher has been just a little hard on him. The child is thereby prevented from accepting his treatment as just and right, and feelings of rebellion and resistance are fostered in him toward the correction that was attempted. And in very frequent instances the parent or teacher, after having administered some corrective discipline, ruins the entire result of this by taking some palliative measure thereafter, making the child feel that she agrees with him in considering the treatment harsh or unjust and that she is "taking back" what she has done or said by way of correction.

Too much attention cannot be paid to seeing to it that, in all matters where the child's will has to be crossed, his desires given wholesome direction, or some corrective measure taken, he does not develop and retain a feeling of rebellion, but that he comes to accept the situation as just, to acquiesce therein, and to go on happily and contently. It is often in the mistaken measures taken to get this feeling of rebellion or injustice out of the child that the harm is done. The measures taken are palliative, or are given as a sop, instead of being directed toward establishing confidence in the person who has given the correction and toward developing a contented acceptance of the justice of the procedure. Care must be taken in discharging the feelings of rebellion and injustice that the measures used are in no sense palliative, in no sense given or received as a sop to the feelings. It is not enough that the child merely stops feeling rebellious, angry, injured, or ill-used, when he is corrected, directed, or has his will crossed. These feelings must be replaced by a sense of the justice and fairness of what has been required of him, by a sense of confidence in the act and in the intentions of the persons who may be dealing with him; and, if old enough to have such understanding, he must be given some notion of the fact that the course being pursued is good for him, whereas the one he might have been pursuing or might have wished to pursue would be harmful. In so far as this change of feeling takes place and some understanding of the value to him of what is being done is developed in him, he *accepts* in the deepest and most significant and healthful way the direction and correction. For now what has been done has received the support of his feeling life, instead of its opposition, and without this support, any sort of intellectual understanding of the rightness and value of the course pursued is of negligible value. Unless such fundamental acceptance in the feeling life is brought about with the child, then the rebellion that has merely quieted down for a time because of some other reason will inevitably flare out again at the next incident in which his will is crossed or his desires opposed, or else will turn into some form of deceitful and hypocritical attitude of outward acceptance, simply biding its time to work in less obvious and less explosive ways against any sincere obedience to those who seek to mold and train and educate. When the outward expressions of rebellious feelings, or the feelings themselves, are merely allayed through some sort of propitiation or palliation, or through punishment, without there having been developed any genuine acceptance in the emotional life of the situation that has aroused the rebellion, then there has not been any real growth in obedience brought about, but only repression or momentary truce. Genuine obedience is a matter of inner attitude and not of outward performance alone.

How this discharge of rebellious feelings is to be secured, and just how to engender the opposite feelings of willing and contented acceptance of direction and control, cannot be written down as a rigid and exact formula or prescription. The methods used must depend in part upon the age and the individual characteristics of the child that is being trained. But no matter what is said or done—however well, in itself, it may be suited to the degree of understanding that the child has and to the nature of the particular situation—it will be of no avail if accompanied by the wrong spirit or attitude on the part of the one who is dealing with the child. It is the spirit and attitude of those who deal with the child that are of the most vital importance. In the very young child, the whole response is to the emotional elements in the situation rather than to the ideational content of what is said. But it is true also, throughout life, that it is not so much what we say as how we say it that brings reactions from others, both children and adults. The attitude of sincerity, of fairness and justice, of patience and genuine regard, of confident and quiet, kindly authority are absolutely indispensable in securing the contented acquiescence of any child in matters of discipline, criticism, correction, and control. In the very young child there may be little or no understanding of what is said, but there is no lack of sensitive response to the emotional tone present. In the older child there may be very good understanding of what is said, but this is not and cannot be accepted by him so long as there remains any emotional resistance in him, and so long as there is lacking in the adult the emotional attitudes mentioned above.

When the child, on being fairly and justly dealt with in correction and criticism by parent, teacher, or companion, does not accept the treatment as fair, but has generated within him feelings of rebellion and injustice, he is in exactly the right state of mind to be misled by that person, be he playmate or parent, friend or stranger, who offers the pat of condolence, the false sympathy, the soft word, and, perhaps, in addition, some tidbit to eat or some show of special favor, thus adding to the solace of wounded and rebellious feelings the satisfaction of appetite. And because of this feeling of rebellion and injustice, the child is helpless to refuse the proferred sweetmeat or favor or sympathy, even though he may know that he ought to do so, just because it accords with his own deep hunger for approval, his desire to receive credit and have sympathy, even though it be not rightly earned. Through such incidents as these there is built into him that tendency that through all his life will make it hard and sometimes impossible for him to face reality where it touches his emotional life. Upon such a person the human parasite always seeks to fasten itself by offering the appearance of real satisfaction, by appealing to his appetites, by show of apparent sympathy with and understanding of the tender feelings of its misguided host. And her host sells himself out for the husks she has to offer because of his undisciplined emotions, his inability to discriminate between the false and the true, his lack of courage, his desire to have this fictitious peace and quietness, never having experienced the satisfactions that come from facing and dealing with reality in a robust and straightforward manner, never having acquired such control over his appetites and feelings as to be proof against being enslaved to her through them.

That the parasite type and its host may stand out more clearly, the following outline sketches are presented:

Study I

This study is of a married woman of about forty, in good health, who had had good educational advantages and whose husband occupied a position of prominence in his profession.

At forty years of age, by her abject selfishness, her hatred for work, her unwillingness to carry any responsibility as wife, homemaker, and mother, and by her constant process of parasiting upon her husband, taking everything and giving nothing in return, this woman had brought her husband to a condition of serious ill health because of his grief, anxiety, and despair over her failure. He was hopelessly despondent about himself, his affairs, and his young children, who were in a serious condition morally and physically through the mother's neglect and her constant active opposition to any attempts made by the father to give them the necessary moral training.

Her method of procedure from childhood had always been to make an appearance of being busy or of being willing to be busy and of carrying responsibility, and yet always to have some one else actually do the work or carry the responsibility, while she got the credit; or else she would contrive to get excused from doing anything on grounds that still left her on a pedestal of approval with those with whom she wished to stand well that she might gain something from them. As a child she had learned that by tantrums, feigning delicate health, inducing fainting spells, etc., she could at any time avoid obedience and get excused from doing anything to help her mother. As she grew older, she used the plea of delicate health to avoid taking a responsible part in any matter of a social sort that savored at all of work. Furthermore, the father greatly contributed to this state of affairs in that he opposed any attempt on the part of her mother to correct her, offering such pleas as that she was not "really very strong," that she was "sensitive and highstrung," and that she was really such a good girl in every way that she should be favored. Thus the girl played the father off against the mother to get her own way and to keep up her life of disobedience and shirking. The training of this parasite actually began in infancy, by the opposition of the father to any sort of direct, persistent, systematic, orderly treatment of the child, to whose every cry he was insistent that immediate attention be given, so that while still in the cradle she learned to have tantrums to secure attention and get what she wanted. This was followed on the part of the father by every sort of foolish attention and coddling and adulation as she grew older, and before she was six years old she had learned just how to avoid any obedience, how to avoid taking any direction or submitting to any restriction through show of ill health, through having a "nervous spell," and finally, in early girlhood, by inducing fainting spells at will. She had also through her girlhood learned how to get herself in with people by a great show of willingness to oblige, and by a false show of delicate tastes, a false show of modesty, of daintiness of manner and the like, so that before she was adolescent she had the complete stock in trade of a parasite. Her way was always to get what she wanted out of people through the use of her trickery and then to turn on them in some way and discredit them with others, selling them out in every subtle way she could, though always seeking to do this in such a way as to protect herself. No one who ever befriended her but was turned upon in this cruel fashion as soon as she could get the favor she wanted in some other direction. Moreover, as soon as her machinations had secured her a place with any one, as soon as any one showed any interest in her or any dependency upon her, then she ceased to make effort and settled down to be the recipient of all the favors, giving nothing in return, but always on the lookout to strengthen herself in some other direction. She would never work for or make any effort for or any return to those who cared for her, those upon whom she could in any way trade because of their relationship to her, of their interest in her or dependence upon her. Yet she never ceased to try to make it appear to them and to others that she was making all the effort she could, that she really could not be expected to do more on account of her frail health or her sensitive disposition; or else, by cruel tantrums or storm of tears and show of being greatly abused, she tried to get them to remove the responsibility from her, to take back any sort of blame they might have put upon her and to cease exerting any pressure upon her to make effort.

This harshness and cruelty she would never show openly to any but those who she felt would condone such conduct in her, or over whom she felt she had sufficient power to be able to throw off her mask of pretense of humility and gentle willingness and force them by her tantrums into doing her the service she desired. The significant thing to note here is that the mask of assumed gentility, humility, soft and ingratiating willingness, sweet docility, of eagerness to render any service and show of sympathy, never made her any friends among discerning, healthy-minded people, never deceived any but those who were ready to be deceived thereby. For the parasite has little chance to fasten itself upon any one except the person who by nature and training has been prepared to become her dupe, her victim, her host. No one who has learned to face reality, who is not looking for false sympathy, who is not blinded by his own feelings, is ever deceived long enough by such a person to permit her to become fastened upon him. And yet a man of splendid intellectual qualities, of unusually good preparation for one of the highest and most difficult of professions, was in her net. He had found out, very soon after his marriage to her, that he had married a sham, but in his false pride and false sense of duty he had set to work to cover her up, to conceal in every way the fatal mistake he had made, and to try to make his ideal come true in her through giving himself unreservedly to her in the most loyal way. And the more he gave, the more she took and the less she returned to him in any conceivable way, until at last she had almost destroyed him. How could it be that she should ever have deceived him so that he would turn to her as the one to be his life mate?

The answer is to be found in the inherent nature of the man and the way in which this nature had been molded and fashioned by his childhood's environment and training. A child of unusually sensitive nature, great emotional capacity, and fine intelligence, he had been protected by his too indulgent mother and sisters against facing reality in the shape of control and discipline and correction by his father. They did not understand that by this method of treatment they were forming in him a nature that would ever turn away from those who would meet him and deal with him in an upstanding way and give him honest and healthful criticism—a nature that would turn toward those who would offer a specious protection to his feelings, which had never been trained to robustness and firmness and stability. It was this show of softness and sympathetic understanding, of docility and false tenderness, of helplessness and delicacy of manner and nature that attracted him to this girl and made him her dupe, and brought him and his children to ruin after years of wasted life and misspent effort.

Study II

This is a study of a young man of about thirty, of good family, well educated, and possessed of admirable qualities had these been given constructive and healthful direction. This young man found himself on the verge of ruin through having become infatuated with and finally married to a woman who was a typical parasite. She was, furthermore, far beneath him in birth, education and intelligence.

She was able to fasten herself upon him because of certain qualities in the organization of his emotional life which betrayed him into this serious situation.

This study is of great value in that it shows how, out of the failure to understand and direct the emotional life of the child, there come those forms of motivation which bring the youth and the adult to later disaster. Such wreckage not only robs the unfortunate victim of the realization of any sort of desirable and worthy life for himself, but, through him, brings sorrow and loss to others and loss to society because of his failure to come to any development that would turn his abilities into constructive and productive channels, making him a distinct social asset instead of a social loss.

He was the youngest of a large family, being many years younger than his next older brother. Throughout his childhood, his older brothers and sisters had the chief care of him, his mother being in delicate health and well on into middle life when he was born. As a child he did not receive the coddling and nursing that he craved, and through this he developed a deep sense of injustice as well as through the fact that he never could understand why he was not given the same treatment as other young children, cousins and neighbors. Because he was of delicate health, a different régime had to be prescribed for him from that which he saw other children enjoying; for example, his play and rest hours had to be carefully regulated, where more robust children were being allowed greater privileges, and when sweets were passed about amongst cousins and acquaintances, he was not permitted to indulge in them. In these apparently trivial matters, and in the host of other measures taken to protect and care for him according to his physical needs, lay the secret of the development of intense rebellion against his family, of a deep feeling of being unjustly and unfairly treated. So early did this show itself that at four years of age he refused with great show of childish bitterness some presents that were offered to him, saying that it was no use to accept them for they would just be taken away from him. From a careful study of the facts, it appears that everything was being done for him in the spirit of greatest kindness, out of real concern for his best good, but that because those in charge of him failed to understand the causes of the resistance that he set up, failed to secure his contented acceptance of the things that were being done for his good, failed to secure his confidence and his affection, there were formed in him great emotional repressions and deep dissatisfactions which, as he came to his adolescent years, were prominent factors in turning him to seek outlet for his pent-up emotional life in sex perversions. Adolescent sex perversions and uncontrol can be traced back in a large percentage of instances to repressions and resistances developed in the emotional life in the pre-adolescent years. There is no greater protection for the adolescent against the formation of destructive sex habits than a happy, contented ongoing in the pre-adolescent childish years, during which he learns to take direction and to exercise control over his childish appetites and desires without repression, rebellion, or resistance.

In turning to this girl in his young manhood for satisfaction, he was motivated at the first by purely sex attractions. But she quickly intrigued him by making a great pretense of understanding him, of being sorry for him because of the ill-treatment which he felt he was receiving from his family. And in her turn she made appeal to him by relating how she, too, was in such a plight because ill-used and betrayed by others, and she made protestations that he was kind and fair and just to her and treated her with a consideration that others had never shown her. In his state of mind he was ready at once to be the chivalrous knight and come to the aid of any one who, like himself apparently, was suffering from gross injustice and particularly of one who was offering him just that sop to his feelings and making that appeal to his appetites which he craved. Blinded thus by his own sense of injustice, going to her in his repression and unhappiness and finding specious relief and specious sympathy and understanding, he was persuaded by her to provide opportunity for her to get some schooling on the pretense that she might be saved out of the life to which injustice had brought her. And though at first he had not the slightest intention of marrying her, she so played upon this sense of injustice of his, and so appealed to his own pride and to his appetites and his falsely directed sense of chivalry, that she got him entirely into her power. But once she had him in her net through marriage, she began to drop her mask of pretense, and he found himself not only without the sympathetic understanding which he had supposed he had found in her, but in the hands of a most ruthless parasite, whose one aim was to possess herself of what he had and then to destroy him.

The progress of this man from childhood to maturity reveals a steady turning away from reality, a progressive failure to face and deal with facts, until he was brought to ruin because of the perversions and repressions generated in his emotional life. If, as a small child, he had been understood, so that the rebellions that came up in him had been discharged and replaced with the attitude of confidence and trust toward those who had him in charge, then the sublimation of his emotional life would have begun at that point, and there would not have been developed that tendency to turn away from those genuinely and sincerely interested in him and truly loving him to the false and destructive pretenses of the parasite.

Until we are able to understand and properly educate the emotional life of the child, we shall continue to have history repeat itself in the constantly recurring story of the parasite and its host.

GRAIL OR DRAGON*

NOTES ON THE PRIME TASK OF HUMANITY

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ONE would like to see the world try out the following bold hypothesis: *that the prime task of society is the destruction of evil.* We should not soon expect a science of the destruction of evil, but we might well hope for more rapid progress in the art of its destruction—as we might say, the malecidal art. As a trivial step in the technique of this malecidal art, I shall below offer a new classification of the various evils of the world, a proposed *Regnum Malorum.* Before inviting the reader into so depressing a kingdom, I feel that I must argue first for the hypothesis itself.

That the prime task of society is the destruction of evil must seem to some a bold hypothesis, to others little more than a truism. Of course, if one talks about a prime task, one is not necessarily talking about the mean task. Moreover, one might be talking of a task primary in time or of a task primary in the logical confrontation of the whole problem of society. It is in the latter sense that I wish to use the term prime. For although it is plain that many persons might well turn from what they are doing to the destruction of circumambient evils, yet there are, no doubt, plenty of good people doing constructive tasks from which it would be a shame to withdraw them. But I want to argue that, in any general confrontation of the total problem of society, we ought to look to the destruction of evil as a primarily indispensable and essential part of our task, logically speaking.

Let me brush aside a few minor objections to the program of the destruction of evil, the malecidal program. How many there are amongst us who have confidence in various political and economic schemes for what they are rather apt to term social reform or social regeneration. To be sure, these principal words, reform and regeneration, no doubt secretly concede the point that the destruction of evil is the logically initial task of society—else why reform and regeneration at all? Those who see a light through the economic trees are apt to have little patience with those who linger in the forest swamps, as they regard evil. To be sure, if evil were merely negative, the need for reform, regeneration, readjustment, rehabilitation, would not be on the cards for us at all. Hence we find some economists who regard the social primacy of the malecidal art as altogether overbold, in view of political and economic possibilities whose realization would turn the flank of evil altogether, and there are other economists who would consider our hypothesis a truism or a triviality also, since a plan for positive benefit is to their minds identical with the negation of evil. I cannot think that they are right.

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* *Editorial note:* Among the papers of Dr. Southard was found this article, which was read at Worcester, Massachusetts, November 14, 1919. We are very glad of the opportunity to place it before the readers of MENTAL HYGIENE. It is Dr. Southard's last contribution to a subject in which he was greatly interested.

Let us turn to another group of thinkers, the juristic group. These men are apt to think that all our interests can, in the end, be secured by legal order. They must regard the evils of this world as in the long run of a very low vitality—doomed to die of malnutrition when the true and positive interests of man are conserved by a reformed legal order. But although the jurists have, no doubt, altogether too strong a hold on the world, yet their grasp is, perhaps, not upon vital organs. Moreover it is to be observed that in the course of decades or centuries jurists come around to the great philosophical, scientific, or ethical views of men more concerned with facts than with the ordering of them. Moreover it is doubtful whether jurists will be found even to consider a hypothesis like ours not couched in legal terms.

There are moralists to consider. Many moralists run so little afoul of evils in their cloistered lives that the technique of evil destruction, the malecidal technique, would strike them as rather a cheap and harmful technique. Having solved, to their thinking, their own individual problems by some species of asceticism, these moralists take a rather anæmic interest in evils which are so easy to avoid, if not to meet. They do not value highly an art of evil destruction, at least when they compare it with some glorious plan of imitating in our lives a lofty and golden norm. Hence we should, no doubt, find amongst the moralists a few militant spirits who will accept the malecidal program explicitly because they have always acted upon the plan implicitly. A cloud of witnesses amongst the saints will come to mind. Perhaps the moralists will not so readily fail to get the point of the world's difficulty as will sundry economists and jurists. The moralists will probably not so readily confound and identify the positive benefic program with the negative malecidal program. Good sturdy moralists are well aware of what you might call the positiveness of negation, the absoluteness of a relative difficulty—in short, the actuality of evil.

As for the educators—in the more dry and intellectual sense of the term—they will be found emphasizing the senses and the intellect rather than the emotions and the will. They will hardly think of evil as a fit topic for the adolescent mind. And they will have their ideas directed at the adolescent mind rather than at the adult mind. Despite the treasure house of maxims to the contrary, educators will not soon be convinced that the thing for the world to do is to find out what its evils are before it climbs to heights. (See *The Grammarian's Funeral, passim.*) These intellectualists will interpret very literally the phrase, "Get thee behind me, Satan." The *Retro me* was, no doubt, a most malecidal bit of method and did not imply any false "forget-it" philosophy or any notion of putting the devil out of one's mind. No doubt there are maxims and maxims, and looking on the bright side has its adolescent values. As for us poor adults, we have to look upon the dark side, and the first step in malecidal technique will be to measure and probe the kingdom of darkness.

Perhaps we might hope for aid from physicians. Physicians must practically cope with the intenseness of evils. But physicians are immersed, not to say drowned, in the concrete. They do not ordinarily generalize or range about in other branches than their own. They are as guilty in this regard as the jurists, and their modesty has its values. Yet, since they lead the malecidal contingent so far as individual victims of evil are concerned, perhaps we should require some of them to bear witness.

In short, perhaps we should obtain assistance from physicians, from moralists, from economists, from teachers, and from jurists, in something like the sequence given, when we come seriously to reckon with the main question. Let us turn to this main question.

The destruction of evil—is not this the first study of society? Were evil once destroyed, still would not society's continuing task be the prevention of further evil? Indeed, will it not for centuries be the main task of society to destroy and prevent evil? But what is evil? How shall society proceed? Is not this program for the primary destruction of evil hopelessly vague? How can we prevent what we do not understand?

At first sight a depressing retort. The task of evil destruction looks almost hopeless. Let us for a moment concede the vagueness of the program, though—as will shortly develop—only for a moment. There are enthusiasts, particularly amongst the moralists, who have an alternative plan. They have what they call a constructive plan. In fact, if one begins to talk about the value and pleasure of being a malecide, one is rather apt to be met with the triumphant counter, "But, my dear fellow, why not be constructive?" Why, indeed, why not augment the good in the world? The benefactive plan, as we may call it, must, we think or hope, in the end beat out the devil and all his works; benefactive agencies will, we feel, conquer malefactive agencies. Perhaps even evolution will see to it, and in the struggle for social existence malefactions will be replaced by benefactions, evils with goods.

You will now see the turn of the argument. You said to me that the program for the destruction of evil was a vague one. I replied that the benefactive program for the construction of goodness is a vague one. Is not the program for the greatest good almost hopelessly vague? In any case, how can we lay down even in embryo that which we do not understand any better than we understand evil? Conceding for the moment that we deal with two equally vague programs—for the destruction of evil and for the construction of good—it looks as if we must choose a program on some other basis than the unknown and indefinite nature of the material. We want the good, we want not the evil. If I am equally at a loss to define what is evil and to define what is good, of what avail to me is the ancient maxim, "Knowledge is power"?

But, I submit, the situation is not quite an impasse. It is a truth as old as the hills—indeed the hills were carved out of the old truth—that to tear down is easier than to build up. Destruction is easier than construction. It is easier to scuttle than to cork, to cut than to heal, to ravel than to weave—in short, to analyze than to synthesize. To be sure, the ancient hills look as they had been built up with a purpose, and there are on record a few doubtful experiments like that of Pelion and Ossa. But in point of fact Pelion and Ossa both are products of destruction well enough known to geologists.

If evil and good are both equally hard to define, and if knowledge and wisdom about them both linger, we have a resource left—we can look to our powers. All our human history and all our prehistoric intimations, and perhaps the entire history of our particular evolution of this planet, give us the tip that we shall be quite as well prepared to destroy as to build up. The formula lovers have provided the idea that life reduces to nutrition and reproduction, to the maintenance of the individual and the maintenance of the species, to food and to sex. I do not know whether these formulæ are thoroughgoing. But it is plain that if nutrition is the most important task of every organism, then we that live must be primarily skilled in the powers of destruction; we destroy either the animals or the plants that we must in the last analysis use for our lives. Nor does the history of reproduction fail to show a good many destructive elements; indeed a whole group of workers have regarded the maintenance of species as based on a struggle for existence in which destruction is the big line. Even the history of reproduction in the human race shows a long tale of destructive processes. Nothing seems more synthetic than a honeymoon, yet does not the wedding trip rehearse in simple form the history of millenniums of wife capture? According to the psychologists, as we proceed from militancy to industrialism there is less and less wife capturing in the overt sense, but as between militancy and industrialism who shall say that militancy is not the more ingrained in our natures?

Who, I ask, would not rather be St. George than Sir Galahad? It is indeed a man of rare elevation who would prefer a Holy Grail to a slain dragon. If we may believe the books, it is easier to slay a dragon than to get a grail. I say, then, that our powers of destruction are more ingrained in us than our powers of construction, and I should like to turn this tendency to account. We should set our powers of destruction on evil. So far as we are destructive, we should be malecides.

A further step in the argument. We should not have conceded above that our ideas of evil are as vague as our ideas of good. Perhaps we know—or *can* know—more about evil than of good. The vocabularies are everywhere full of terms for evil, perhaps fuller of terms for evil than of terms for good. Moreover it is abundantly clear that there are many kinds of evil. It often seems that there are more kinds of evil than there are kinds of good. Pains are sharper than pleasures. Discomforts perturb us more than comfort pleases. If you concede for the sake of your argument that the primacy of the malecidal task is a working hypothesis for society, then the next step is plainly to find out what evils, precisely, there are. The vocabularies divulge their names. Something has been done in the classification of sins by churches and the classification of crimes by courts, but on the whole who will deny that little or nothing has been done in the fundamental ordering of all the multitudinous evils, troubles, difficulties, maladjustments—not merely sins and crimes, but all other forms of evil? Nor can we say that the older estimates of sin and crime based upon the ideas of recompense or retribution must stand to-day.

I think on the whole it will prove easier to classify the evils than to classify the goods. Evil tends to break into *evils* sooner than good into various *goods*. It is much harder to be concrete about goods than to be concrete about evils. The grail is more abstract than the dragon. It is easier to see dragons of many kinds than even to conceive several kinds of grails. Moreover, lest we pity poor Sir Galahad too much, we must remember that the Galahad program was not in all respects a pallid meliorism, but undertook much destruction of evils by the way.

We used George Eliot's good word "meliorate." We are all meliorists, I suppose, if we are social reformers or social workers in any wide sense of those terms. We are all trying to meliorate the situations we face. Our only question is as to the method of procedure, the technique of the melioration. Shall it be by definitely benefactive routes or indirectly in the malecidal manner? What I feel and am trying to say is, the destruction of definite evils is a better technique to begin with than the construction of indefinite good.

To sum up my points in the reverse order of my consideration here, it may be laid down that:

1. Evil is easier to perceive than good is even to conceive;
2. Evil subdivides into evils more readily than good into goods;
3. Evils get more clearly into our minds than goods do and should by the same token be more definable;
4. As between destruction and construction, we men are built more for destruction than for construction, or at all events are more used to destruction;
5. We should take advantage of this ingrained destructive trend and adopt a "melioristic" technique *in the first instance* of destroying definite, concrete, observable evils rather than of trying to construct indefinite, abstract, hardly conceivable good; and
6. Get the Grail, but First Slay the Dragon.

I have thus given my main arguments for the hypothesis of evil's primacy in the realm of social tasks. I promised a small contribution to the technique of evil's destruction; indeed, if I had nothing concrete to offer, I might be charged, like many of my opponents, with tilting at windmills. Though a bad anticlimax may follow, I must risk it. What I have to propose is a new classification of evils—evils taken, that is to say, in the most general way and gathered for the most general purpose of social attack. I here go upon the conception that the evils of society are quite definite enough to form an aggregate. I think it is possible to hold, furthermore, that the elements in the aggregate can effectively be placed in an order of consideration. And though the order I select may be charged with medical prejudice, and though I myself cannot escape the charge of being a physician, yet I am bound to say that I think the evils do form a well-ordered aggregate of the sort laid down. It is a commonplace of logicians that the kinds of classification of given aggregates are infinite.

This particular classification is leveled at diagnosis and thus in the end also at treatment.

I will present forthwith in tabular form the major groups of evil as I see them.

KINGDOM OF EVILS

(Regnum Malorum)

Diseases or defects of body and mind	*Morbi*
Ignorance: misinformation and educational deficiencies	*Errores*
Vices and bad habits, non-psychopathic	*Vitia*
Legal entanglements	*Litigia*
Poverty and other forms of resourcefulness	*Penuriae*

My whole contention is that it would be to society's prime advantage to take these phenomena as in some sense positive evils, which it would become our duty forthwith to destroy and in future prevent. Still, it is the habit of the world to look upon these matters from another side, from the so-called constructive side, and it may help us here to rehearse our grouping in the more ordinary terms. Thus we might speak of society's task as fivefold—namely, as hygienic, pedagogic, moral, juristic, and economic—and we might describe the values of the world in these terms, specifying the evils that appear as medical, educational, ethical, legal, financial; in short, there is a considerable vocabulary of roughly interchangeable terms for all these conditions, whether we take them on the constructive or on the destructive side.

I shall not here discuss sundry minor questions of terminology. Thus educators sometimes conceive that morality and moral training form a part of the educational program, but I think that on the whole the distinction between mental and moral still holds, at least for practical purposes, and that the blocking together of intellectual teaching and moral training does us logically no good. That probably the teacher ought to be also a moralist, none at the present day can be found to deny, but that the task of conveying information and the task of character formation are in any respect logically identical may well be doubted. Even if there is a rather wavy line between teaching and training as a matter of our schools, nevertheless the problem faced from the standpoint of evils brings very sharply out forthwith the distinction between ignorance on the one hand and vice on the other.

Again, the theologian might inquire whether the evils peculiar to theology—the sins—may enter into this classification. So far as the sins are matters of the authority of a given church for their classification, they can evidently have no general application in communities of different faiths. Roughly speaking, however, the sins, no doubt, with the exception of original sin (not here dealt with) would fall in the group of the *vitia;* and their practical handling is a matter of training, rather than of teaching, as we earlier employ those terms.

The jurist might have a special quarrel with the grouping, since he might wonder how the condition of being at law is in itself an evil. To be sure, we know lawyers are flippantly certain that being at law is somewhat of an evil. We crave to establish in law schools courses of preventive law that shall operate some time in the millennium to the abrogation of all need for being at law, and a program of preventive law has begun to appear in some of the more advanced law schools here in America. It is plain that the innocent parties in all law suits are in an evil plight, whether through loss of time, energy, or money, and it is plain that those who are not innocent are doubly in evil plight, since they are both the causes of the evil and are themselves entangled in their own difficulties. Divorce sins, chancery sins, automobile-ordinance breaking—here are sundry legal entanglements, all of which, I think it is no exaggeration to say, are evils. The word *litigia* appears broad enough to cover not only court cases, but arbitrations and other cases settled out of court.

Where are the evils, the artist inquires, of ugliness, æsthetically speaking? Of course there must be a limbo of evils not covered in these five major groups, and the uglinesses perhaps fall into this limbo. In the meantime I am not entirely sure that the uglinesses of the world are as bad as the beauties of the world are good. In short, an æsthetic theory might be founded upon the hypothesis that beauty is a positive without a negative. However that may be, I have not found it practically necessary in my particular small corner of the world to elect the uglinesses into a major group of evils.

There are certain advantages in taking evils as no more than five. We may count them on the fingers of one hand. We may attach disease to the thumb, ignorance to the index finger;

to vice we may give the central position on the longest or middle finger; to the legal entanglements we may offer the ring finger as a peg, though with an apology to the said finger for its more tender task of time immemorial; and upon the little finger we may hang poverty and the kindred evils, thereby defining for ourselves our conception that when the other evils are done away with, the evils of poverty and the other forms of resourcelessness will remarkably dwindle.

Alas, how complicated a world, with these five groups of evil! How much simpler were we, in common with the lowest animals and plants, to suffer chiefly from disease and to have no other evils in our lot! The primates, and especially man, must make a virtue of their vices, make good out of their evils, achieve construction by means of destruction—such is the burden of our main hypothesis. Three things combine in eight ways, or into seven if we omit the eighth way in which all three are absent. Four things combine in sixteen ways, or fifteen if we omit the negative combination. Five elements combine in thirty-two ways, but the thirty-second is that combination in which all five elements are negative. How fortunate for analysis if the Kingdom of Evils contains but five major groups, for then the combinations will not run beyond the tale of thirty-one, unless perchance there be some among us who belong in the thirty-second group, as stainless as Sir Galahad. The combinations of six elements rise to sixty-four, of seven elements to one hundred twenty-eight, and so on. Accordingly let us derive some comfort from the fact that we are not yet complicated enough, if this analysis holds, to show more than five kinds of trouble.

Thus dogmatically set out, I fancy that the *Regnum Malorum* may appear to some readers as either erroneous or of little practical value. To show that it is erroneous would entail, I believe, the substitution of some other and better scheme, which I think one would gladly adopt, or perhaps the entire point of view of throwing the evils so prominently on the carpet is not well conceived. Yet I think the reader who has come to this point in my discussion, and has not long since thrown the paper down in disgust, will concede at least hypothetical value to the conception. It is clearly impossible for any one nowadays to grasp either the main facts of medicine, pedagogy, ethics, jurisprudence, and economics, to say nothing of numerous other sciences and arts. All I can offer in favor of the practicability of this scheme is practical work in one of the last resorts of society in its analysis of evil—namely, a psychopathic hospital. The psychiatric branch of medico-social work was for the first time established in a public institution upon a systematic and organized basis in the Psychopathic Hospital at Boston. During the seven years of this work, a considerable progress was made in social case analysis and a considerable list of scientific papers dealing with facts and figures has been issued from the hospital.

I have before me the card catalogues of social difficulties encountered in this hospital. The evils confronted by the staff can, of course, not adequately represent the statistical configuration of evils in the world at large. Primarily we deal with the acute, curable, incipient, and dubious cases of mental disease, such as are not in the first instance commitable as chronic patients to asylums. We constantly confront some of the most acute and delicate situations that the inhabitants of this world have to encounter, but in addition thereto we have a good many school problems and juvenile problems which throw into sharp relief a variety of intellectual and moral issues. The courts of recent years have become acutely interested in the psychiatrist's estimate of delinquents, and many a case of so-called crime turns into a case of mental disease under the scrutiny of the mental expert. Moreover, the poor we have always with us, and they offer us the typical economic difficulties confronted by all social workers. The statistical figures are of no general value as above stated for any appraisal of the world's sheaf of evils. However, as indicative of the general nature of the Psychopathic Hospital problem as it shows itself in the type of social work so-called, I might point out that amongst approximately a thousand so-called "social cases," there were 430 different kinds of problem in the card catalogue, distributed as follows: 72 types of problem were on their face pathological problems, belonging to the evil group above termed *morbi*. The ranging of the intellectual problem was much smaller, only 16 kinds in all *(errores)*. This is not to say that language difficulty and lack of schooling were not hopeful facts in numbers of cases; the point is that there were 16 kinds of educational problems that came to the surface as main factors in the patients examined. The largest toll of problem types was afforded by the moral group *(vitia),* of which there were 157. The next largest group is, however, that of legal entanglements *(litigia),* of which there were 105 different kinds. The poverties and other forms of resourcelessness numbered 80 kinds. Thus, taking the kinds of problem on their face, we found that our hospital was dealing with acute, curable, and incipient and other mild forms of mental disease; that the kinds of problem in the order of strength were as follows:

Moral	157
Legal	105
Economic	80
Medical	72
Educational	16

In appraising this order, it must be remembered that many of the groups might be represented by but a single case, yet the sequence above mentioned is not, I think, a false one save, perhaps, in one respect. If we take these major groups of evil from the standpoint of the individual patients and limit ourselves to the problems that have occurred and re-occurred to a number exceeding fifty, we shall then again find that the moral problems lead. There were 369 cases of moral problem. There were 205 cases of legal difficulty. There were 66 cases of purely medical difficulty. Thus the order of the types as reproduced approximates the order of the number of cases affected; but as intimated above with the exception of this parallelism, there were 539 cases in which economic trouble was found. To be sure the non-economic troubles outnumber the economic ones (640 as against 539), but still the economic difficulties lead in point of number of cases affected. It is, no doubt, this numerical superiority of the economic evil in the world which has attracted the attention of so many reformers and which has incited them to the thought that the proper treatment for the great world evil is a new social, economic, or political system which shall attack the question of poverty and other forms of resourcelessness at first hand.

Nor can I prove from Psychopathic Hospital material (even granting its tremendous repetitions of all the finer shades of the individual problems in any community) that economic reform should take a secondary place. Yet my general impression, derived from a study of the cases underlying these figures, is that a vast majority of these particular economic troubles is of pathologic and especially of psychopathic origin. The like is true of the great group of the moral problems, so many of which turn out to be not genuine moral problems at all, but a question of certain ingrained psychopathic tendencies which ought to be met in other ways than by mere moral training. (Of course moral training is undertaken in psychopathic cases upon a highly individualized and differentiated and sometimes apparently very partial basis; the point made in the test is that moral training suited for the average man is ordinarily not of the curative kind of ethical attack which we make upon the psychopathic. This is, I grant, debatable ground, but I hardly think the debate is at issue in the text.) Amongst the types of moral problem, there were five species represented in the 369 cases, but of these three are not infrequently, or are perhaps most frequently, psychopathic rather than moral problems. The like holds for marital discord, as we see it in the special atmosphere of the Psychopathic Hospital clinic. As for marital discord in the typical American home, I am far too astute to render an opinion.

Amongst the legal troubles, sex delinquency stands high, but here again in our particular atmosphere we are prejudiced by finding a large majority of our particular sex delinquents psychopathic, a situation which, no doubt, the great outside world does not parallel. For the ways of sex delinquency and the sex habits of the world vary so under the varying conditions of society that it would be the height of absurdity to insist upon any psychopathic nature with sex delinquents as a whole. In the last militant state of the world and even in the reconstruction period, we perceived and are still aware of the effects of a laxity of sex life which can in no wise be regarded as psychopathic.

But these statistical figures are, I insist, of no general value, however interesting they are to the hospital specialist. My point in speaking of them at all is to insist upon the concrete source of the classification here put forward. What right has any one to claim particular insight into all the evils of the world? Who would have more right to some general notion of the different kinds of evil than workers in a psychopathic hospital? Physicians, nurses, social workers, probation officers, and all the assistants in the medical clinic there might conceivably get a distorted view of the problems of evil in the world—though for my part I am not at all sure that there is any evidence of such distortional view in these malecidal specialists—but whatever their distortion of statistical view, it seems clear that the very last things in point of evil sooner or later fall under the eye of the group of malecides that form psychopathic-hospital staffs. All of which is, perhaps, enough said in justification of the particular concrete source from which these ideas of the *Regnum Malorum* were derived.

EDUCATION OF MENTAL DEFECTIVES IN STATE AND PRIVATE INSTITUTIONS AND IN SPECIAL CLASSES IN PUBLIC SCHOOLS IN THE UNITED STATES

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THE early history of the education of the mental defective, dating from Itard's attempt in 1800 to educate a wild boy found in a forest in the center of France—"this boy could not speak any human tongue and was devoid of all understanding and knowledge"—continuing through the difficult period of great public distrust and doubt, when there was almost a total lack of recognition of the importance of the problem, up to the present-day widespread interest in state care and treatment of mental defectives, has been admirably covered by Doctor Walter E. Fernald in his article, *The Growth of Provision for the Feebleminded in the United States.*[1] The period covered has been one of constant and splendid achievement.

At present there are only five states in the Union that have made no separate provision for the urgent needs of this large, helpless, and potentially dangerous class of dependents. These states are West Virginia, New Mexico, Arizona, Nevada, and Utah.

But no state of the Union is doing more than touching the surface of the problem. Though the great social mischief of which the mentally defective are capable is now becoming fully realized, still not a single state has as yet taken cognizance of one-tenth of its mental defectives.

The care of the feebleminded in separate institutions in the United States per 100,000 general population, and the relative position each state occupies in its recognition and provision for this class in special institutions is shown in the following chart, the material for which has been gathered by the Bureau of Statistics of the National Committee for Mental Hygiene:

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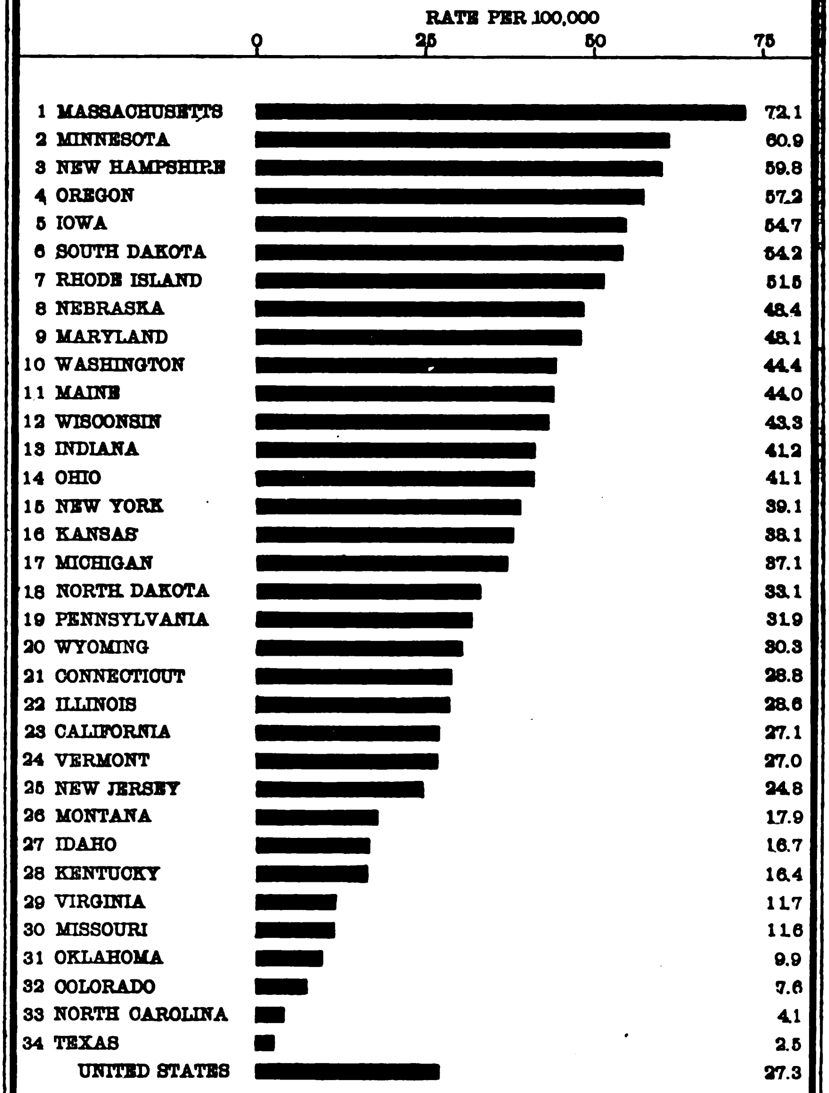
[1] MENTAL HYGIENE, Vol. I, pp. 34-59, January, 1917.

FEEBLEMINDED IN STATE INSTITUTIONS FOR THE FEEBLEMINDED IN THE UNITED STATES, WITH RATES PER 100,000 OF GENERAL POPULATION, JANUARY 1, 1920



Despite all the progress that has been made, the largest and most urgent need in connection with the problem of the mentally defective is still greater institutional provision. The keynote to any and every program for properly handling the feebleminded is the institution, and around it must revolve all other state machinery. During the year 1919 Tennessee, Alabama, Georgia, Florida, Mississippi, and Hawaii, which had not hitherto provided institutional care for their feebleminded, made appropriations for such schools; Massachusetts, Minnesota, Illinois, Indiana, and Wisconsin appropriated large sums for the construction of new institutions; while South Carolina, Oregon, New Jersey, South Dakota, Nebraska, and other states provided appropriations for the construction of additional buildings.

In a recent article[1] we called attention to the fact that, with this increased program for institutional development, greater care and more serious attention were being devoted to the consideration of the types of buildings and methods of constructing and operating such institutions. We now wish to emphasize one of the most important reasons for which the state builds these institutions, and that is the training of the defective children entrusted to it for care and protection. There exists a strong public sentiment in every American community to the effect that every child has a legitimate right to be educated and trained according to its need and capacity. Especially do parents plead for the education of their children while they are young and capable of improvement. But aside from this quite proper sentiment, it is a matter of practical economy and plain common sense to train these children for useful employment, in order that they may either earn the cost of their maintenance in an institution or support themselves in the community, rather than to let them grow up as dependents, vagrants, and delinquents.

In order to secure information concerning the character and extent of the educational training now being given to the children in public and private institutions for the feebleminded in the United States, a questionnaire was sent out

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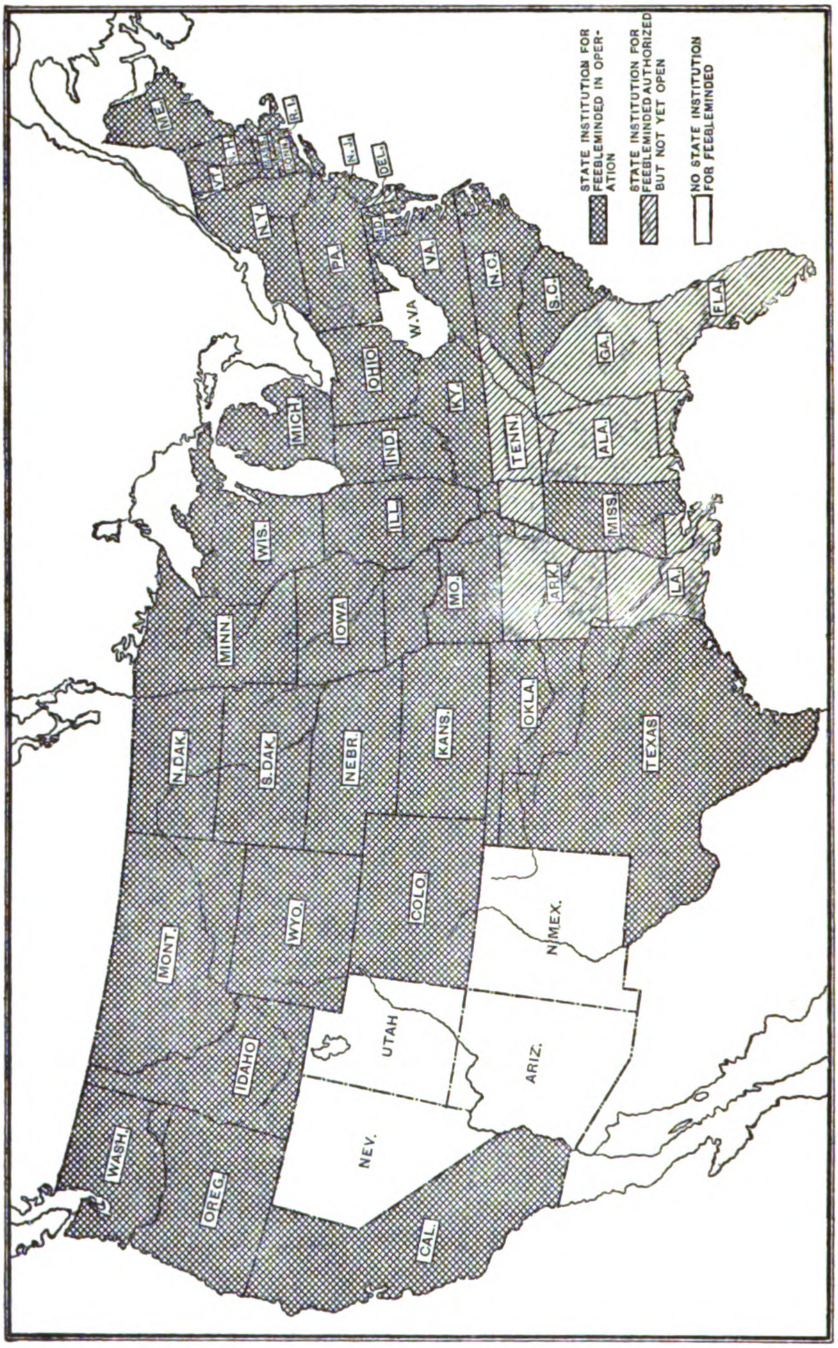
[1] *State Institutions for the Feebleminded,* by V. V. Anderson. MENTAL HYGIENE, Vol. IV, pp. 626-46, July, 1920.


STATE INSTITUTION FOR FEEBLEMINDED IN OPERATION
STATE INSTITUTION FOR FEEBLEMINDED AUTHORIZED BUT NOT YET OPEN
NO STATE INSTITUTION FOR FEEBLEMINDED
ME.
N.H.
VT.
MASS.
CONN.
R.I.
N.Y.
N.J.
DEL.
PA.
MD.
VA.
W.VA
N.C.
S.C.
OHIO
KY.
GA.
FLA.
MICH.
IND.
TENN.
ALA.
ILL.
MISS.
WIS.
MO.
ARK.
LA.
IOWA
MINN.
OKLA.
N.DAK.
S.DAK.
NEBR.
KANS.
TEXAS
MONT.
WYO.
COLO.
N.MEX.
IDAHO
UTAH
ARIZ.
NEV.
WASH.
OREG.
CAL.

State provision made for the feebleminded in the United States, January, 1921 during January, 1920, asking for data under the following headings:

1. Number of children in institution
2. Number in attendance at school
3. Number of teachers
4. Annual salary of head teacher and assistants
5. Ages of children included in the educable group
    a. Mental age
    b. Chronological age
6. Character and extent of educational training
    a. Sense training. (Extent and character of work done in detail.) Also, number now being instructed in sense training
    b. Grade work. Methods used in teaching; number of grades taught; amount of time each pupil spends in grade work; number of pupils in each grade; and any additional facts bearing upon academic work given
    c. Music. Number of pupils being taught
    d. Physical training
    e. Manual training
    f. Industrial classes
7. Number of mental defectives now in community on parole
8. After-care of paroled and discharged pupils

Replies were received from 30 state institutions and 17 private institutions, caring for 26,774 feebleminded children. The following table shows the state and private institutions represented and the number of children in each institution. It also shows the number and per cent of children in attendance at school. A very wide variation in the amount of educational work done by various institutions is indicated, ranging all the way from no educational provision at all to well organized facilities which provide for the training of as high as 63.80 per cent of the children in these particular institutions.

Table I—Children receiving school instruction in state and private institutions for the feebleminded in the United States

INSTITUTION	Children in Institution	Children in School	
		Number	Per cent
Public			
Sonoma State Home, Eldridge, Cal.	1,456	*	....
Lincoln State School, Lincoln, Ill.	2,214	468	21.2
Indiana School for Feebleminded Youth, Fort Wayne, Ind.	1,469	523	35.6
Iowa Institution for Feebleminded Children, Glenwood, Ia.	1,471	418	28.4
The State Institution for Feebleminded, Frankfort, Ky.	424	*	......
Maine School for Feebleminded, West Pownal, Me.	346	107	31.2
Wrentham State School, Wrentham, Mass.	1,236	629	50.9
Michigan Home & Training School, Lapeer, Mich.	1,628	384	23.6
Missouri Colony for Feebleminded & Epileptics, Marshall, Mo.	590	95	16.1
Montana School for Deaf & Blind, Boulder, Mont.	100	80	80.0
Nebraska Institution for Feebleminded Youth, Beatrice, Neb.	700	175	25.0
New Hampshire School for Feebleminded, Laconia, N. H.	331	104	31.4
Burlington County Colony, New Lisbon, N. J.	93	†	......
New York City Children's Hospital, Randall's Island, N. Y	1,528	276	18.1
Rome State School, Rome, N. Y.	1,955	355	16.6
Syracuse State School for Mental Defectives, Syracuse, N. Y	611	340	55.6
Letchworth Village, Thiells, N. Y.	643	170	26.4
The Caswell Training School, Kinston, N. C.	105	67	63.8
State Institution for Feebleminded, Grafton, N. D.	284	102	35.9
Institution for Feebleminded, Columbus, Ohio	2,486	301	12.1
Oklahoma Institution for Feebleminded, Enid, Okla.	336	84	25.0
State Institution for Feebleminded, Salem, Ore.	478	68	14.2
Pennsylvania Village for Feebleminded Women, Laurelton, Pa.	25	0	......
State Institution for Feebleminded of Eastern Pennsylvania, Pennhurst, Pa.	1,111	350	31.5
State Institution for Feebleminded of Western Pennsylvania, Polk, Pa.	1,992	463	46.6
State Colony for the Feebleminded, Austin, Texas	125	55	44.0
Vermont State School for the Feebleminded, Brandon, Vt.	113	38	33.6
State Custodial School, Medical Lake, Wash.	620	315	50.8
Southern Wisconsin Home for Feebleminded & Epileptic, Union Grove, Wis.	105	24	22.9
Wyoming State School for Defectives, Lander, Wyo.	98	35	35.7
Private			
Beverley Farm Home & School for Normal & Backward Children, Godfrey, Ill.	60	35	58.3
Powell School for Backward & Nervous Children, Red Oak, Iowa	58	44	75.9
Hospital Cottages for Children, Baldwinville, Mass.	113	41	45.1
Miss Moulton's School, Chestnut Hill, Mass.	3	3	100.0
Hillbrow School, Newton, Mass.	7	7	100.0
Parkside Home School, Muskegon, Mich.	5	5	100.0

*Data not received.

†Farm and domestic work only.

Table I—Children receiving school instruction in state and private institutions for the feebleminded in the United States—Concluded

INSTITUTION	CHILDREN IN INSTITUTION	CHILDREN IN SCHOOL	
		Number	Per cent
Trowbridge Training School for Unusual Children, Kansas City, Mo.	11	11	100.0
Miss Compton's School for Children of Retarded Mentality, St. Louis, Mo.	10	10	100.0
Bancroft School for Mentally Subnormal Children, Haddonfield, N. J.	50	43	86.0
The Training School, Vineland, N. J.	492	165	33.5
The Florence Nightingale School, Katonah, N. Y.	24	22	91.7
Pennsylvania Training School for Feebleminded, Elwyn, Pa.	926	207	22.4
The Brookwood School for Backward Children, Lansdowne, Pa.	14	13	92.6
The Woods School, Roslyn, Pa.	35	35	100.0
The Bristol-Nelson School, Murfreesboro, Tenn.	20	20	100.0
Gundry Home & Training School for Feebleminded, Falls Church, Va.	99	46	46.5
The St. Coletta Institute, Jefferson, Wis.	174	100	57.5

It has been interesting to note the change that has taken place in our attitude toward the value of formal efforts at educating mental defectives. It was the hope of the early pioneers—Itard, Séguin, and others—to arouse the dormant faculties of the feebleminded through the physiological education of the senses in order to develop "the dynamic, perceptive, reflective, and spontaneous functions of youth." For a period real enthusiasm existed over the possibilities in this plan of training, and the early schools were all purely educational in character. Later a reaction set in when it began to be realized that little could ever be accomplished in actually developing the intelligence of feebleminded persons.

When it became fully appreciated that feeblemindedness was incurable, that "once feebleminded always feebleminded," interest in the attempts to educate the feebleminded greatly diminished and public attention became centered upon another element of the problem, the heredity of the feebleminded. Studies of such families as the Jukes, the Kallikaks, the Ishmaelites, and others, and investigation of pockets of defect in various communities throughout the country brought realization to the public of the social menace and burden of feeblemindedness. Close upon these investigations came reports from state prisons, reformatories, workhouses, jails, houses of correction, and courts, showing the great frequency of feeblemindedness amongst juvenile delinquents, adult criminals, vagrants, prostitutes, and the like. Criminologists began to recognize the mental defective as the backbone of the vast army of recidivists (repeaters) passing through the courts and filling the state and county correctional institutions. There followed a period that may be called the custodial period, marked by the slogan: "Lifelong segregation or sterilization of all feebleminded persons."

We are now entering upon a third period. The practical working out of such theories as permanent segregation or sterilization of all defectives, however good these theories may be, has been found to be impossible in the present state of public conscience; so that such leaders as Fernald are standing for state-wide supervision of all mental defectives, early recognition and diagnosis of every feebleminded child in the public schools, opportunity for special-class training and after-care supervision of every defective child in the state who needs such care, and finally institutional care and intensive training for those unable to profit by special-class instruction in the community. The keynote to this program is, as Fernald says, to be found in the fact that those defectives whose defects are recognized while they are young children, and who receive proper care and training during their childhood, are as a rule not especially troublesome after they have been safely guided through the period of early adolescence; and in many instances, as Bernstein, Wallace, Fernald himself, and others have demonstrated, may be handled with safety and profit in the community. Emphasis is again on the educational phase of the problem of feeblemindedness—fitting the defective for useful service in the institution or, in the case of those for whom it is possible and who have community value, for active lives as respectable, law-abiding, self-supporting members of society. It is of interest, therefore, to know just what the institutions of the country are doing in the way of training their educable children.

PUBLIC AND PRIVATE INSTITUTIONS FOR THE MENTALLY DEFECTIVE

The following table indicates the equipment of each institution in the way of teachers, the number of pupils per teacher, and the maximum and minimum salaries received by teachers.

Table II—Teachers in institutions for the feebleminded, ratio of pupils to teachers, and salaries of head teachers and other teachers

INSTITUTION	Teachers	Pupils per Teacher	SALARIES			
			HEAD TEACHER		OTHER TEACHERS	
			Minimum	Maximum	Minimum	Maximum
PUBLIC						
Sonoma State Home	8	......	$1,080	....	900	......
Lincoln State School	15	31	1,200	2,133.24	780	1,080
Indiana School for Feebleminded Youth	16	43	....	*1,080	576	*648
Iowa Institution for Feebleminded Children	17	24	....	750	400	500
Maine School for Feebleminded	3	35	780	1,300	780	1,040
Wrentham State School	15	41	960	1,320	540	840
Michigan Home and Training School	15	25	1,000	1,200	720	900
Missouri Colony for Feebleminded and Epileptics	†	†	....	900	......	600
Montana School for Deaf and Blind	5	16	....	840	600	720
Nebraska Institution for Feebleminded Youth	5	35	900	900	660	780
New Hampshire School for Feebleminded	4	26	....	‡750	550	‡600
New York City Children's Hospital	27	10	....	1,700	696	1,200
Rome State School	12	29	900	1,200	600	720
Syracuse State School for Mental Defectives	22	15	....	‡990	400	600
Letchworth Village	6	28	....	900	......	720
The Caswell Training School	1	67	‡900	....	......	......
State Institution for Feebleminded, North Dakota	5	20	....	1,080	550	650

* Part maintenance
‡ For less than 12 months
† Not reported
For addresses of institutions see Table I

Table II—Teachers in institutions for the feebleminded, ratio of pupils to teachers, and salaries of head teachers and other teachers—Concluded

INSTITUTION	Teachers	Pupils per Teacher	SALARIES			
			HEAD TEACHER		OTHER TEACHERS	
			Minimum	Maximum	Minimum	Maximum
Institution for Feebleminded, Ohio	17	16	......	600	400	570
Oklahoma Institution for Feebleminded	3	28	600	600	......	......
State Institution for Feebleminded, Oregon	5	13	750	......	600	......
State Institution for Feebleminded of Eastern Pennsylvania	12	29	......	750	550	600
State Institution for Feebleminded, of Western Pennsylvania	17	27	600	900	540	720
State Colony for Feebleminded, Texas	3	18	......	1,200	......	720
Vermont State School for Feebleminded	1	38	450	......	......	......
State Custodial School, Washington	7	45	......	660	......	......
Southern Wisconsin Home for Feebleminded and Epileptic	1	24	800	......	......	......
Wyoming State School for Defectives	2	17	900	1,200	900	900
PRIVATE						
Beverley Farm Home and School for Normal and Backward Children	2	17	300	......	......	......
Powell School for Backward and Nervous Children	4	11	1,000	......	......	......
Hospital Cottages for Children	2	20	†	......	......	......
Miss Moulton's School	1	3	†	......	......	......
Hillbrow School	3	2	......	1,000	......	650
Parkside Home School	2	3	†	......	......	......
Trowbridge Training School	3	3	†	......	......	......
Miss Compton's School for Children of Retarded Mentality	5	2	†	......	......	......
Bancroft School for Mentally Subnormal Children	13	3	1,380	3,480	1,140	1,320
The Training School	12	13	......	1,350	420	900
The Florence Nightingale School	3	7	1,200	......	......	......
Pennsylvania Training School for Feebleminded	15	13	1,020	......	360	600
The Brookwood School for Backward Children	5	2	......	......	480	600
The Woods School	10	4	†	......	......	......
The Bristol-Nelson School	†	......	780	......	360	480
Gundry Home and Training School for Feebleminded	3	15	600	......	480	......
The St. Coletta Institute	10	10	†	......	......	......

† Not reported

For addresses of institutions see Table I

Excluding certain institutions that have no school work at all, we find that the number of teachers per institution varies all the way from one to twenty-seven. The New York City Children's Hospital and School at Randall's Island, among the public institutions, has both the largest number of teachers and the smallest group of pupils (10) to each teacher. The salaries at this institution are also the highest reported.

For satisfactory work in the training of defectives, it is generally agreed that small classes are necessary. Most institutional men complain of the great lack of funds for an adequate teaching staff. Many would like to have not more than fifteen pupils per teacher, although the majority of public institutions for the feebleminded are having to conduct their school work on the basis of thirty-odd pupils to a teacher. The character of educational work done in these institutions cannot, to be sure, be judged purely from the size of the teaching staff or the salaries paid, for there are certain public institutions in this country where the character of training given is highly efficient although the number of teachers is comparatively small and the total number of pupils per teacher large. However, the success of the educational work in these institutions is dependent upon the skill and zeal of certain exceptional teachers, who are succeeding in spite of their handicaps—a personality factor that cannot be estimated in a general study of this kind. Other things being equal, a fair judgment of the educational work of an institution can be based on the size and equipment of the teaching staff.

Ages Included in Educable Groups

The reports show that the chronological ages of the pupils have a wide range (three years to sixty years). The mental ages range from one year to sixteen years, although in general the range is from three years to twelve years.

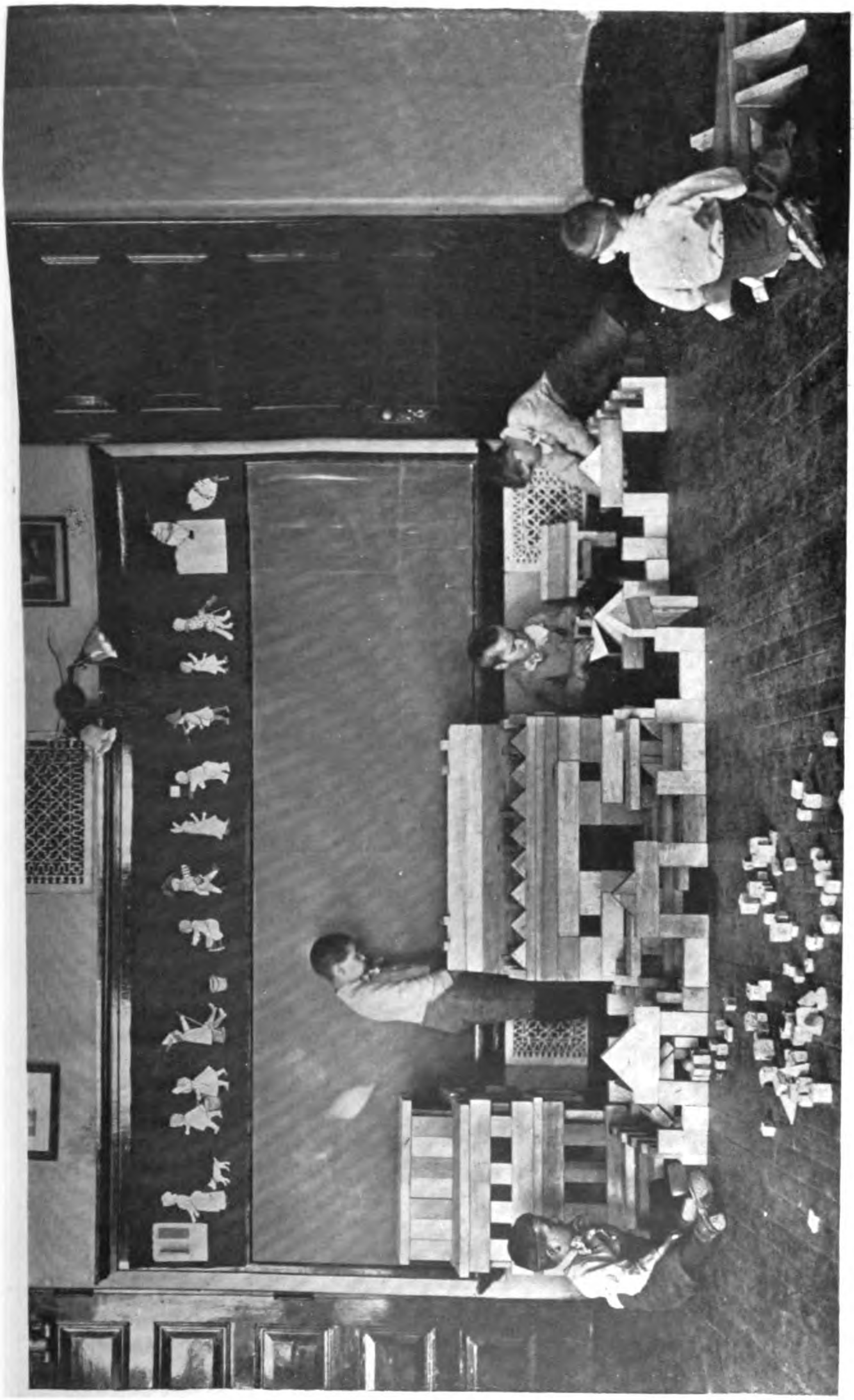
It is doubtful whether any form of school training shows permanent results for children below the mental age of three years. Many men are beginning to doubt the wisdom of keeping idiots, for whom there is nothing to offer but custodial care, for years and years in the kindergarten.

In a study of 108 defective children carried out by Miss Lindley, not a single defective of seven years or less Binet age was ever observed to read.

SENSE TRAINING

The development of the brain is indissolubly connected with the use of the sensory apparatus. Touch, taste, smell, hearing, vision, and muscle-tendon sense are the avenues through which the brain receives stimuli for the development of the mind. Sense training, however, does not necessarily need to be a lesson by itself. Every subject taught during the day may lend itself to the training of the senses. Dr. George L. Wallace, Superintendent of the Wrentham (Massachusetts) State School, writes in regard to sense training: "The children's attention is first secured by means of simple games such as colored bean-bag throwing, ball throwing, clapping of hands, marching, stopping and starting at a given signal. In the formal sense work, the children are first taught to associate the old and the new; then the use of each object; then the name. The child associates sugar with candy, turpentine with the cleaning of the floors, the sound of the bell with the dinner bell. From this he is trained to notice the changes in the grouping of objects, persons, etc. Much color work is used; colored blocks are matched to colored squares of cloth. The child picks out various objects in the room that are the same color as his block. Blocks are later matched in regard to color, size, and form. The name of the color is not taught, but is learned incidentally. Simple, active games are used. Circle games and singing games with music. Often colored blocks with bean bags, balls, and tops are used in connection with these games."

"In training the children to dress themselves, button strips—two pieces of cloth, buttons on one and buttonholes on the other—are used. Shoe lacing is also taught. Time is also spent in teaching neatness in dress and manners. In preparation for hand sewing, large, heavy cardboard cards with large holes are used. Colored shoe laces are drawn through. From these the children progress to smaller cards, using worsted and a needle, then to plain sewing—sewing on buttons, etc.



Kindergarten

Grade work

Peg boards, picking up of paper, pincushion work, etc., are used. Instruction is given in carrying wood and stones from one definite location and placing them in another definite location; in shoveling sand from one place to another, etc.; the use of the hammer, first pounding blocks, then using large nails, and gradually using smaller ones; the use of the grub hoe; and, finally, planting and the care of the garden."

This investigation shows that 23 out of 30 public institutions, and 14 out of 18 private institutions, are daily giving formal sense training.

Grade Work

Twenty-three of the 30 state institutions studied are giving regular grade work. In four the scholastic work is not scheduled by grades. In two institutions there is no school work given at all. Sixteen out of 18 private institutions are giving regular grade work.

The Superintendent of the Wyoming State School for Defectives at Lander, Dr. C. T. Jones, writes in regard to methods: "All work is motivated. Arithmetic is taught by playing store, writing for the purpose of letter writing, etc., etc. All school work is correlated with activities in the institution. Each child is given a mental age rating. On the basis of this rating, it is decided about what grade of academic work can be expected from him. He is then given pedagogical tests of achievement, and if he is not up to what can be reasonably expected of him, he is given special training in the lines where he shows the greatest weakness. No child is forced beyond what can be expected from him in view of his mental level."

Dr. O. H. Cobb, Superintendent of the Syracuse State School for Mental Defectives, says regarding methods in grade work, "An adaptation of many methods, plus drill to the *n*th degree. Attempt is made to follow the work required for each grade by the New York State Syllabus in reading, writing, and numbers. These are the only subjects taught except some geography in the 4th and 5th grades."

From the returns it was found that approximately 87 per cent of the pupils who are doing school work in the various institutions for the feebleminded were in the first four grades.

The number of hours pupils spend each day in regular grade work varies in the different institutions from one-half to one and one-half hours in one to five hours in two, but the average amount of time is from one to three hours a day.

MUSIC

Twenty-five state institutions out of 30 studied report systematic efforts in the way of training children in music. Twelve private institutions out of 18 studied report similar training. Twenty-one institutions maintain pupil bands and orchestras. All institutional men are familiar with the fact that music is not only an important element in the happiness of defective children, but a most wonderful factor in its disciplinary effects on these children.

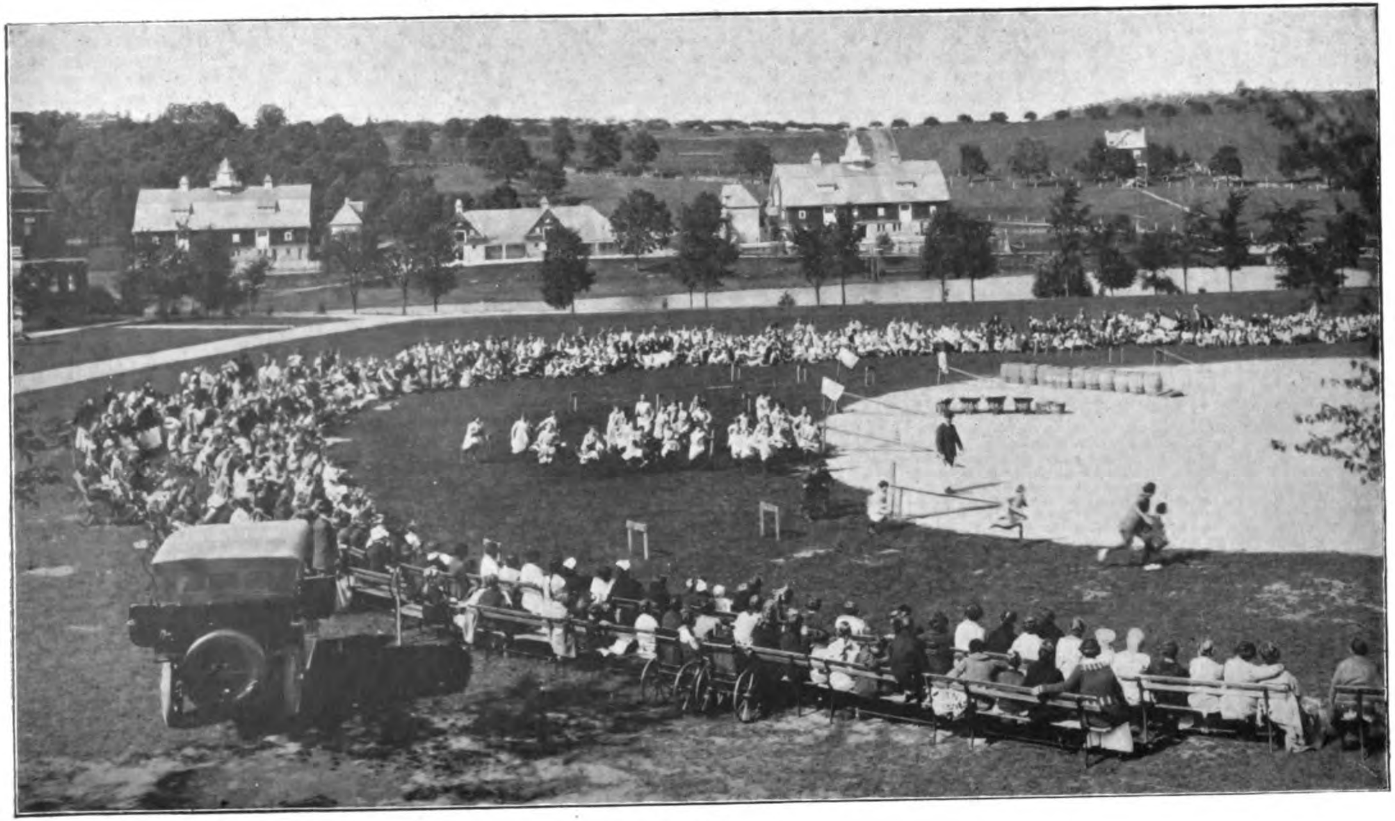
INSTITUTIONS MAINTAINING BANDS OR ORCHESTRAS

1. Sonoma State Home, Eldridge, Cal.
2. Missouri Colony for Feebleminded and Epileptics, Marshall, Mo.
3. Rome State School, Rome, N. Y.
4. Iowa Institution for Feebleminded Children, Glenwood, Ia.
5. Syracuse State School for Mental Defectives, Syracuse, N. Y.
6. Michigan Home & Training School, Lapeer, Mich.
7. Institution for Feebleminded, Columbus, O.
8. Nebraska Institution for Feebleminded Youth, Beatrice, Neb.
9. New York City Children's Hospital, Randall's Island, N. Y.
10. Letchworth Village, Thiells, N. Y.
11. State Institution for Feebleminded, Grafton, N. D.
12. Pennsylvania Training School for Feebleminded, Elwyn, Pa.
13. The St. Coletta Institute, Jefferson, Wis.
14. Powell School for Backward and Nervous Children, Red Oak, Ia.
15. State Institution for Feebleminded of Western Pennsylvania, Polk, Pa.
16. Wrentham State School, Wrentham, Mass.
17. Lincoln State School, Lincoln, Ill.
18. The Training School, Vineland, N. J.
19. State Institution for Feebleminded of Eastern Pennsylvania, Pennhurst, Pa.
20. Indiana School for Feebleminded Youth, Fort Wayne, Ind.
21. Massachusetts School for the Feebleminded, Waverley, Mass.

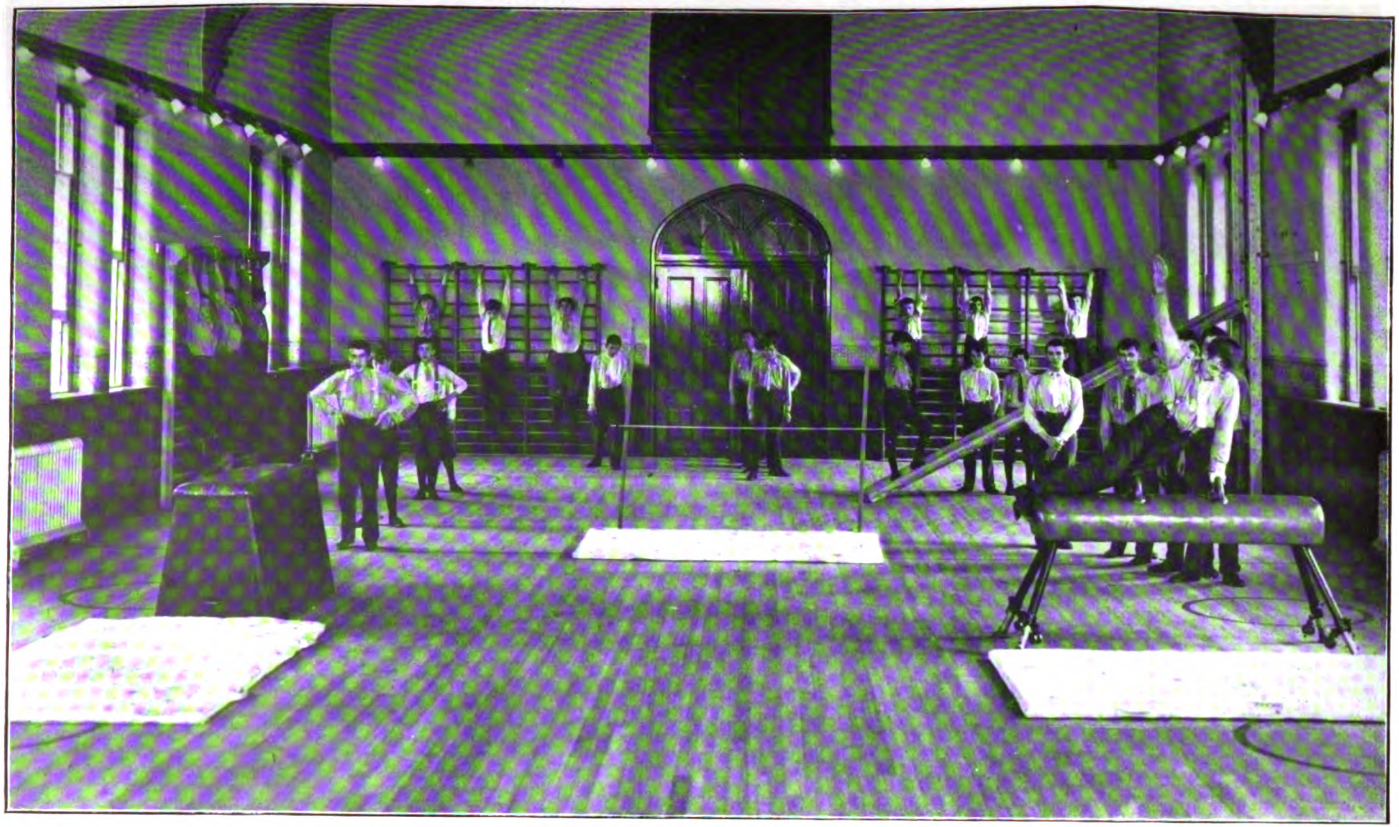
PHYSICAL TRAINING

Physical training has for its aims the improvement of physical health, the correction of physical defects, the building up of physical strength, replacing the shuffling, awkward gait with a graceful carriage, putting "pep," power, and self-con-

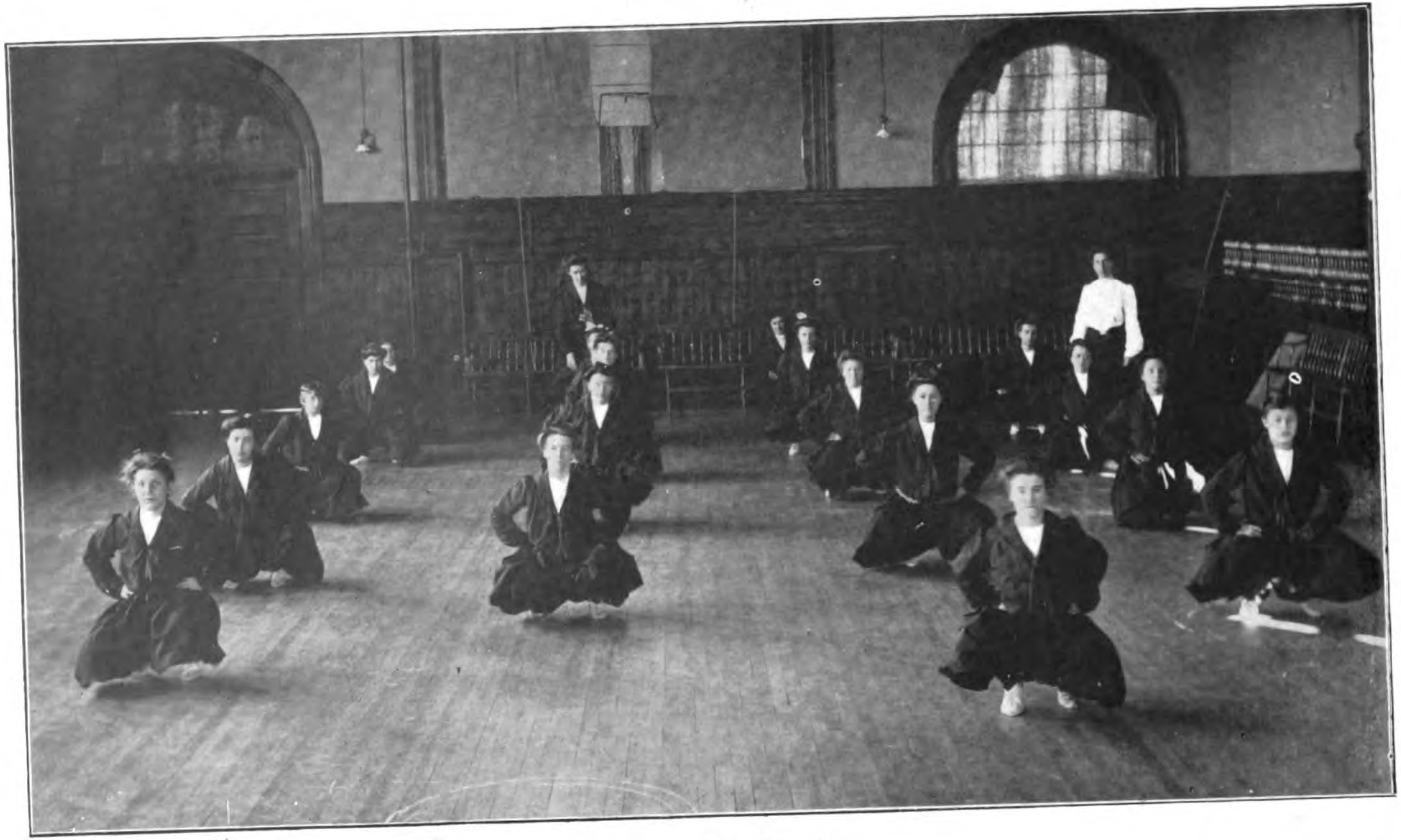
An institution orchestra



Field day



Physical training for boys



Physical training for girls

fidence into the weak, inactive, indolent, apathetic, suggestible, and inadequate personality.

The importance of this phase of educational work is quite obvious. One who has visited the gymnasium at Waverley comes away not only with a conviction of its value as a part of the curriculum of a school for the feebleminded, but with a real enthusiasm as to the possibilities to be derived from this work. The prime requisite for securing successful results from the teaching of physical training to the defective is a well-trained teacher.

Twenty-three out of the 30 state institutions included in this study report regular, systematic work in physical training. Only 13 of the institutions were equipped with gymnasiums, while 14 had regularly employed physical directors. Sixteen out of the 17 private institutions report regular physical training, 11 have gymnasiums, and 4 have regularly employed physical directors. One institution reports: "The character of training consists of games to arouse enthusiasm, gymnastic exercises for posture and attention, marching for carriage, for alertness and rhythm; drill work for rhythm and grace; dancing, folk and social, for rhythm and grace, etc."

Basket ball and indoor baseball, field-day sports and the like are part of the physical-training work in certain institutions.

Table III—Physical training of children in institutions for the feebleminded

INSTITUTION*	Physical Directors	Gymnasiums	Children Receiving Physical Training	
			Number	Per cent
Public				
Sonoma State Home	Yes	Yes	183	12.5
Lincoln State School	Yes	Yes	230	10.4
Indiana School for Feebleminded Youth	Yes	Yes	307	20.9
Iowa Institution for Feebleminded Children	Yes	No	79	5.4
Kentucky State Institution for Feebleminded	.....	.....	.....	.....
Maine School for Feebleminded	No	No	72	20.8
Wrentham State School	Yes	Yes	420	33.9
Michigan Home & Training School	Yes	Yes	266	16.3
Missouri Colony for Feebleminded & Epileptics	Yes	Yes	60	10.1
Montana School for Deaf & Blind	No	No	"all"	100.0
Nebraska Institution for Feebleminded Youth	Yes	.....	53	7.6
New Hampshire School for Feebleminded	No	No	104	31.4
Burlington County Colony	†	.....	.....	.....
New York City Children's Hospital	Yes	Yes	276	18.1
Rome State School	.....	.....	900	45.9
Syracuse State School for Mental Defectives	Yes	Yes	149	24.4
Letchworth Village	Yes	Yes	190	29.5
The Caswell Training School	.....	.....	.....	.....
North Dakota State Institution for Feebleminded	No	No	37	13.0
Ohio Institution for Feebleminded	Yes	Yes	235	9.5
Oklahoma Institution for Feebleminded	No	No	.....	.....
Oregon State Institution for Feebleminded	Yes	Yes	137	28.7
Pennsylvania Village for Feebleminded Women	.....	.....	.....	.....
State Institution for Feebleminded of Eastern Pennsylvania	.....	No	.....	.....
State Institution for Feebleminded of Western Pennsylvania	Yes	Yes	280	14.6
Texas State Colony for Feebleminded	.....	No	45	36.0
Vermont State School for the Feebleminded	No	No	.....	.....
Washington State Custodial School	No	No	100	16.1
Southern Wisconsin Home for Feebleminded & Epileptic	No	No	24	22.9
Wyoming State School for Defectives	No	No	32	32.7
Private				
Beverley Farm Home & School for Normal & Backward Children	No	Yes	40	66.7
Powell School for Backward & Nervous Children	No	Yes	44	75.9
Hospital Cottages for Children	.....	No	34	30.1
Miss Moulton's School	.....	No	3	100.0
Hillbrow School	.....	Yes	7	100.0
Parkside Home School	No	Yes	5	100.0
Trowbridge Training School for Unusual Children	No	Yes	11	100.0
Miss Compton's School for Children of Retarded Mentality	Yes	.....	10	100.0
Bancroft School for Mentally Subnormal Children	Yes	Yes	43	86.0
The Vineland Training School	Yes	Yes	88	17.9

***For addresses of institutions see Table I.**

†Farm and domestic work only.

Table III—Physical training of children in institutions for the feebleminded—Concluded

INSTITUTION*	Physical Directors	Gymnasiums	Children Receiving Physical Tarining	
			Number	Per cent
The Florence Nightingale School	No	Yes	22	91.7
Pennsylvania Training School for Feebleminded	No	Yes	.....	.....
The Brookwood School for Backward Children	Yes	.....	13	92.9
The Woods School	Yes	Yes	35	100.0
The Bristol-Nelson School	.....	.....	20	100.0
Gundry Home & Training School for Feebleminded	No	Yes	42	42.4
The St. Coletta Institute	No	No	100	57.5

*For addresses of institutions see Table I.

All the fittings of a regular gymnasium, such as walking beams, steel bars, ladders, ropes, rings, horses, Indian clubs, dumb-bells, wands, basket balls, and nets, are required.

Manual Training and Industrial Classes

Fernald says: "In this education by doing, we not only have a very valuable means of exercising and developing the dormant faculties and defective bodies of our pupils, but at the same time we are training them to become useful men and women."

Goddard says: "The one thing that fits all of these children, the one thing that draws out whatever is to be drawn out of them, is training of the hand, manual training, industrial training."

Our questionnaire indicates that 20 out of 30 state institutions are equipped for and are giving manual training. Fifteen of these institutions have special teachers particularly trained and fitted for just this type of work. Fourteen of the 17 private institutions report regular manual training. Seven of these institutions have teachers specially trained for giving such instruction.

Twenty-five state institutions and 13 private institutions have regularly organized industrial classes. The various types of work reported are as follows: Basketry, baking, brickmaking, broom and brush making, building, caning, carpentry, domestic science, dressmaking, engine and storeroom work, fancy work, farming, gardening, housework, lace making, laundry work, mattress making, painting, plumbing, poultry raising, printing, net work, sewing (plain), steamfitting, shoemaking, stock raising, tailoring, weaving, woodwork.

Manual and industrial training is rapidly becoming the most prominent feature of the educational training now being given in our best institutions for the feebleminded. Here are being carried on by the pupils themselves carpentry, painting, printing, brick making, shoemaking, tailoring, dressmaking (certain institutions making all of the shoes, dresses, and suits worn by the children), broom and mattress making (one institution now making all the brooms being used in every state institution in the state in which it is located), stock raising, dairying, farming, domestic work, and other industries. These not only prove profitable in the way of financial return to the institution, but form a splendid outlet for the energies of the overactive and disciplinary cases, besides offering an occupational basis for those who are later to be placed under supervision in the community.

PAROLE

It has been fairly well determined that the average adult male defective who is not handicapped by serious difficulties of personality, who has been properly trained in habits of obedience and industry, and who is adequately protected from temptations and evil associates can be safely paroled into the community. Dr. Fernald's report of the results of a survey made of 646 patients discharged into the community from the Massachusetts School for the Feebleminded during a period of 25 years is most significant.[1] He says frankly of these cases: "We honestly believed that nearly all of these people should remain in the institution indefinitely. The majority

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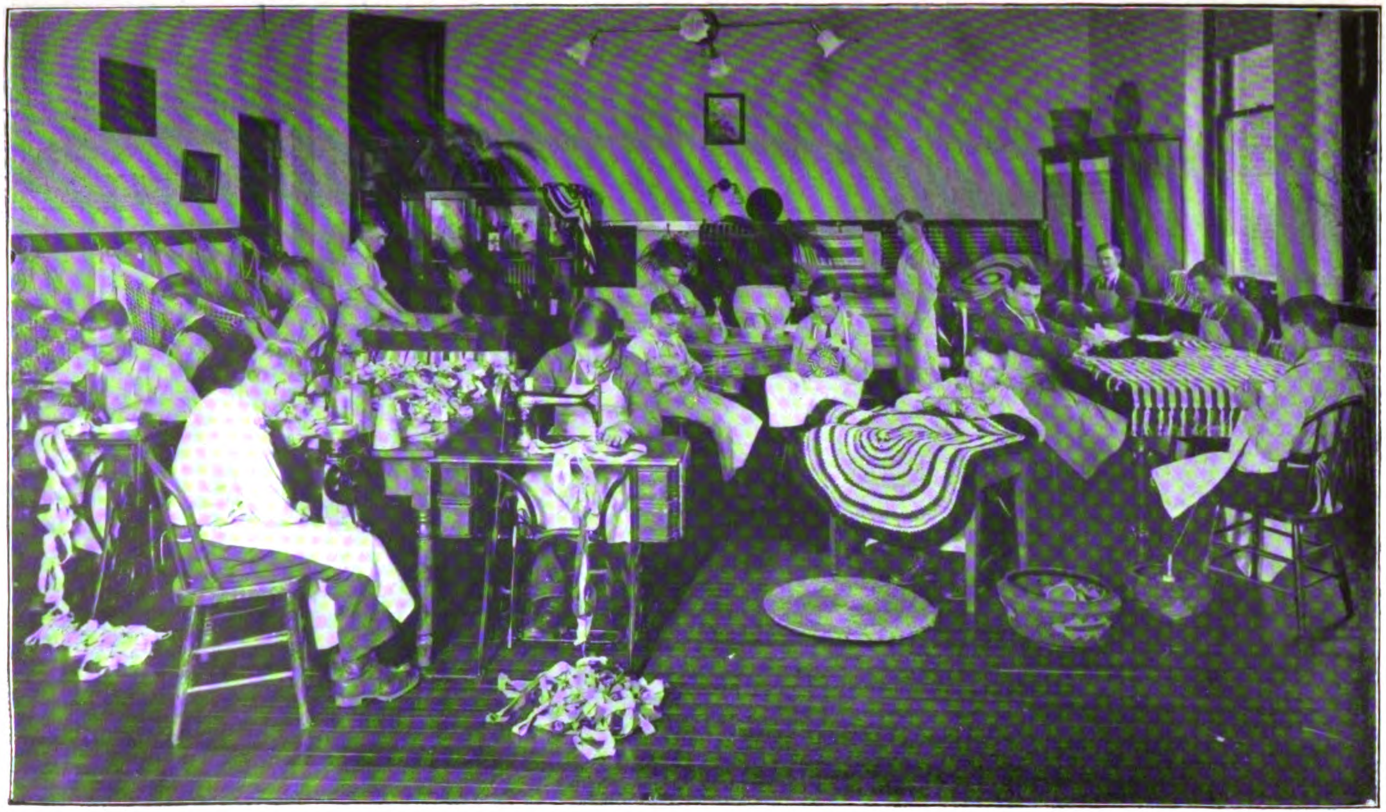
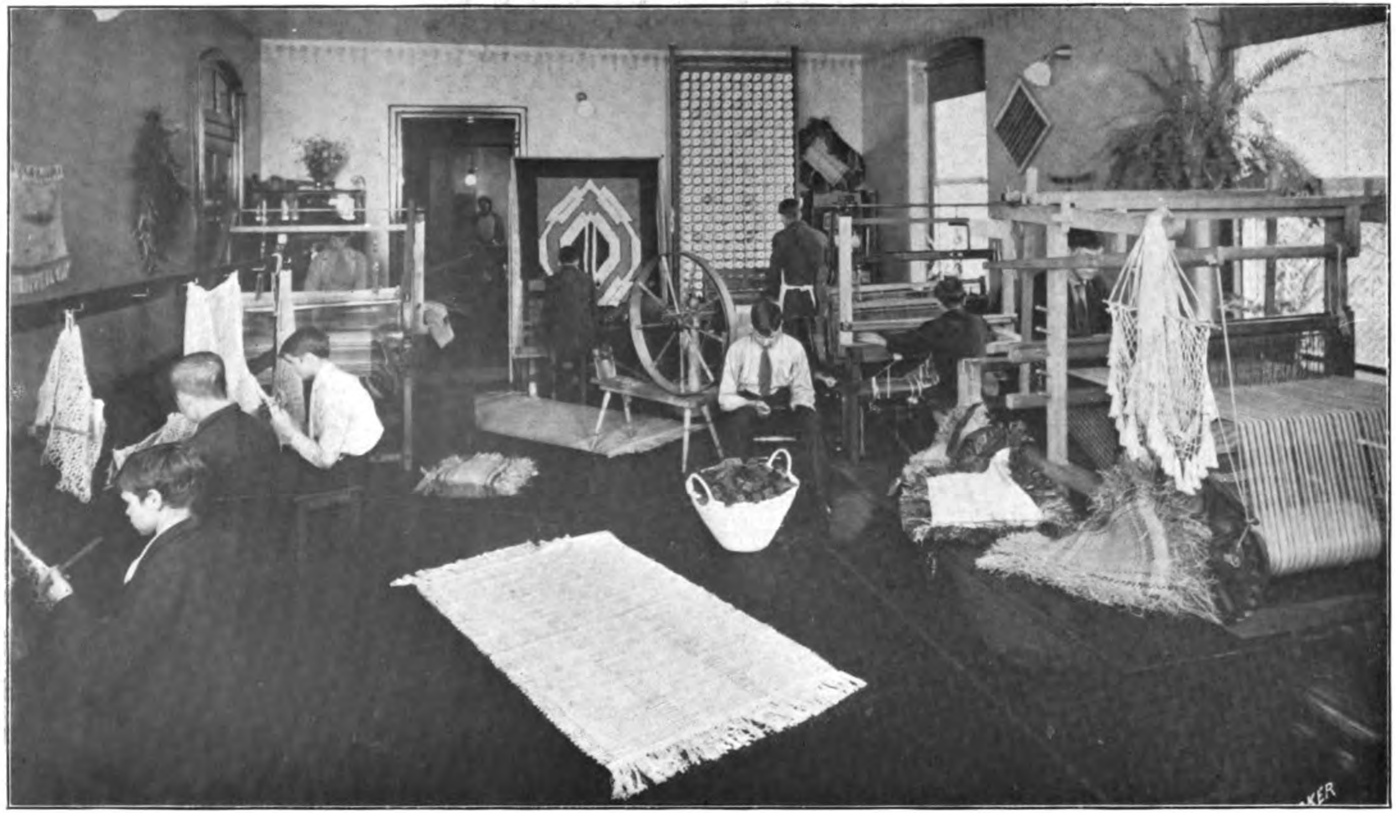
[1] After-care Study of the Patients Discharged from Waverley for a Period of Twenty-five Years, by Walter E. Fernald. *Ungraded,* Vol. V., pp. 25-31, November, 1919.



Rug, basket, and hammock making



Weaving

Dressmaking

Knitting

were dismissed under protest. Not a few of the males took matters into their own hands and ran away."

Of these cases there were 470 males and 176 females.

The following table, quoted from Dr. Fernald's article, shows what actually happened to the 470 males:

Earning a living without supervision	28
Working for wages supervised at home	86
Working at home, no wages	77
Living at home, not able to work	59
Arrested, but not sentenced	23
Sentenced to penal institutions	32
Committed to other institutions	43
Readmitted to Waverley	68
Died	54
Total	470

"Apparently the cases represented in the first four groups, a total of 250, constituted no serious menace to the community at the time of the investigation," says Dr. Fernald.

The 176 female cases are summed up as follows:

Married (11 doing well)	27
Self-supporting and self-controlling, unmarried	8
Living at home under supervision	32
Living at home, not able to do much work	23
Committed to other institutions	29
Died	24
Readmitted to Waverley	33
Total	176

The 27 married women mentioned above had 50 children, 17 of the children had died and 33 were living. The social worker who saw these children was not sure that any of them were defective. "Nearly all of the women had married men whose social status was rather above that of their own parents."

Speaking of the discharged male defectives, Dr. Fernald says: "Their weekly wages ran from $8 to $36. . . . One is in business for himself as a sign painter, a trade he learned at the school. . . . One had saved $2,000; another had bought a house," etc., etc.

"There was a surprisingly small amount of criminality and sex offenses, and especially of illegitimacy. We may hope for a much better record when we have extra-institutional visitation and supervision of all discharged cases. . . . The survey shows that there are bad defectives and good defectives. . . . It is most important that the limited facilities for segregation should be used for the many who can be protected in no other way."

Dr. Charles E. Bernstein, Superintendent of the Rome State School for Mental Defectives at Rome, New York, owing to the fact that many discharged from the institution drifted into the streets and into the courts because of the absence of intelligent supervision, developed a colony plan for handling his girls in the community.[1] The colony represents a step from the institution to the community. Dr. Bernstein is placing groups of high-grade girls, under the careful supervision of well-trained and trusted matrons, at work in domestic service in carefully selected homes in certain localities of the state. A house is rented to which they return at night, and all the comforts and pleasures, as well as the restraints, of regular home life are thrown about them. Eleven boys' colonies and 10 girls' colonies have been developed. Of 200 girls who have passed through the girls' colonies, only 35 have been returned to the parent institution, leaving 165 still maintaining themselves in the community.

As has been pointed out, there are good and bad mental defectives. Some feebleminded individuals possess a very definite community value, are fairly efficient industrially and adaptable socially, and can be properly supervised outside of the institution. There are other feebleminded individuals, popularly known as bad and vicious mental defectives, who possess traits of character and handicaps of personality of such nature as to make it wholly impossible to handle them satisfactorily in the community.

Institutional men throughout the country are now beginning to give serious attention to the possibilities that parole offers in the way of furnishing additional beds to those mental defectives in the community who are urgently in need of institutional care, at the same time that it returns to the community, under careful supervision, well-trained individuals who are capable of self-support and give little or no promise of antisocial behavior.

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[1] See *Colony and Extra-Institutional Care for the Feebleminded*, by Charles Bernstein. MENTAL HYGIENE, Vol. IV, pp. 1-24, January, 1920.

This study shows that 19 out of 30 institutions are paroling mental defectives into the community. In 5 of these institutions the work is being developed as a serious and important phase of the institutional activities. Five institutions have regularly appointed parole officers or supervising agents. One institution has 504 cases on parole. In 14 institutions the work is more or less new and as yet largely on trial, while the remaining institutions evidently have no parole whatever. The following institutions report paroles: Rome State School, Rome, N. Y.; Syracuse State School for Mental Defectives, Syracuse, N. Y.; Michigan Home and Training School, Lapeer, Mich.; Maine School for Feebleminded, West Pownal, Me.; Sonoma State Home, Eldridge, Cal.; The Training School, Vineland, N. J.; Oklahoma Institution for Feebleminded, Enid, Okla.; State Colony for Feebleminded, Austin, Tex.; Nebraska Institution for Feebleminded Youth, Beatrice, Neb.; Letchworth Village, Thiells, N. Y.; Burlington County Colony, New Lisbon, N. J.; Southern Wisconsin Home for Feebleminded and Epileptic, Union Grove, Wis.; State Institution for Feebleminded of Western Pennsylvania, Polk, Pa.; New Hampshire School for Feebleminded, Laconia, N. H.; Wrentham State School, Wrentham, Mass.; Wyoming State School for Defectives, Lander, Wyo.; Lincoln State School, Lincoln, Ill.; Missouri Colony for Feebleminded and Epileptics, Marshall, Mo.; Massachusetts School for the Feebleminded, Waverley, Mass.

This, the most hopeful aspect of work in behalf of mental defectives, is rapidly coming to the foreground of discussion, and gives promise, where carefully planned and properly worked out, of becoming the most prominent feature of the activities of future institutions for the feebleminded.

Special Classes in the Public Schools

As a matter of fact, despite whatever theories there may be as to the complete institutional care of all mental defectives, the great majority must be handled one way or another in the community; and if they are ever to receive any training at all, it will have to be given to them through the public schools.

In size and importance, there is probably no other question more vital to the good of our elementary public school than, What shall be done with our mentally defective children? Between 1 and 2 per cent of the public-school children are unable to profit by the regular grade work because of mental deficiency. In every school district are to be found these unfortunates who are not able to keep step with the rank and file of children. Their stupidity marks them as the dunces in the school, and their simple-mindedness renders them the constant butt of jokes and the perennial source of childish ridicule. They are a burden to the teacher and a constant menace and hindrance to the other pupils in the classes.

But while in school the mentally defective child is decidedly a misfit—he can do no more than his defective brain will enable him to do—in the community in later life the sad combination of his childish mind and his adult years brings him into conflict with laws, customs, and rules of conduct, all of which have been devised for persons whose minds, as well as bodies, are those of adults; so that we find the defective dependent upon charity because of his inability to make a living, and delinquent and immoral because of his inability to appreciate and measure up to adult standards of conduct, or to understand laws, or to protect himself from the advances of others, or to deal with the problems of his own sexual life as the standards of the community require. Jails and brothels, prisons and reformatories, venereal clinics, almshouses, and outdoor relief societies show the price and penalty we are paying for our neglect to provide specialized training in the public schools and lifelong supervision in the community, or institutional care and training at a time when prevention of antisocial tendencies is possible.

Up to the present time educational authorities have shown all too little inclination to appreciate the magnitude and importance of the problem furnished by the mentally defective child.

During the summer and fall of 1919, a survey was made of the special classes for mental defectives in the public schools of the United States. The method employed in obtaining information was by means of a questionnaire sent to school superintendents, principals, and supervisors in 155 cities in the United States. The questionnaire asked for the following data:

1. Total number of pupils enrolled in all public schools, not including high school.
2. Number of classes for mentally deficient children.
3. Number of pupils in such classes.
4. Date of organization of first special class.
5. Are special classes specifically authorized by state law, or are they provided for by state law?
6. Are the special classes segregated in a separate building?
7. Is a distinction made between "special classes" and "ungraded classes" in your schools?
8. How are pupils selected for special instruction? State what tests, if any, are used.
9. Who conducts examinations? Name and title.
10. Course of study and kind of instruction given in such special classes.
11. Author of industrial equipment.
12. What methods of instruction are used?
13. Number of teachers employed in such special classes. What preparation on the part of the teacher is required for this work?
14. Salaries, minimum and maximum, paid to the supervisors and teachers of special classes.
15. What have been the results of the special class work?
16. Are defective pupils supervised outside of schools hours? If so, how and to what extent?
17. What supervision is given these children after they have left school?
18. Is there a department of vocational guidance in your school system? If so, what has been its experience in placing defective children?
19. Name of supervisor of special classes.
20. Are mental clinics for school children conducted? If so, by whom and at what hours?
21. Suggestions relative to the development and usefulness of special classes.

One hundred and twenty-five replies were received, showing cordial coöperation on the part of the school officials. Seventeen cities stated that they had no special classes. The following study contains data bearing upon the organization and equipment of special classes in 108 cities in the United States. These 108 replies represent 1,177 special classes, providing for 21,251 defective pupils. Thirty states are represented in this study:

Alabama
California
Colorado
Connecticut
District of Columbia
Georgia
Illinois
Iowa
Indiana
Kansas
Kentucky
Massachusetts
Michigan
Minnesota
Missouri
Montana
Nebraska
New Hampshire
New Jersey
New York
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
Texas
Virginia
Washington
Wisconsin

The laws of few states require the formation of special classes in the public schools for mentally defective children. In the last three years, however, special classes have by law been made compulsory in five states—Massachusetts, Pennsylvania, Missouri, New Jersey, and New York. In these five states plans are now under way for the recognition and training of every defective child in the state. It is interesting to note that Minnesota, while not making special classes compulsory, provides $100 for the training of each mentally defective child. In this way the state itself appropriates $1,500 for each special class of 15 pupils.

Table IV contains a list of cities that have special classes, indicating the total number of pupils enrolled in the public schools, not including high school, the number of special classes, the total number of special-class pupils, the number of special-class teachers, and salaries paid such teachers.

Table IV—Special classes in public schools of cities reporting, and salaries of teachers for the year 1919-1920

CITIES	Pupils in school excluding high schools	SPECIAL CLASSES			SALARIES of TEACHERS	
		Number	Number of pupils	Number of teachers	Minimum	Maximum
Birmingham, Ala	26,800	2	56	5	....	......
Oakland, Cal	....	12	192	12	*	*
Los Angeles, Cal	....	19	300	19	*	*
San Diego, Cal	....	5	70	5	....	......
Denver, Colo	33,353	29	910	30	$1,000	$1,500
Bridgeport, Conn	20,000	10	200	10	....	......
New Haven, Conn	25,000	7	105	7	700	1,400
Washington, D. C	50,000	15	269	15	750	1,000
Atlanta, Ga	26,000	5	75	5	*	*
Chicago, Ill	258,000	84	1,680	84	900	1,600
East St. Louis, Ill	9,443	2	35	2	*	*
Indianapolis, Ind	....	5	104	6	850	1,200
Burlington, Ia	3,200	1	7	1	1,100	......
Des Moines, Ia	19,738	2	34	1	1,490	......
Ottumwa, Ia	4,591	1	25	1	937.50	......
Kansas City, Kans	14,164	2	28	2	....	......
Topeka, Kans	6,789	6	110	6	1,155	1,200
Covington, Ky	6,000	2	45	2	900	......
Louisville, Ky	....	2	....	2	1,250	......
Beverley, Mass	3,400	§	40	3	1,150	......
Boston, Mass	110,000	75	1,250	75	876	1,452
Chelsea, Mass	6,574	3	45	3	700	1,000
Everett, Mass	7,400	4	50	5	700	1,000
Gloucester, Mass	3,857	1	12	1	650	900
Haverhill, Mass	6,150	1	15	1	1,050	......
New Bedford, Mass	13,654	5	65	7	1,050	1,150
Newton, Mass	5,274	3	62	4	950	......
Salem, Mass	4,139	4	100	4	850	1,000
Somerville, Mass	11,300	3	49	3	....	1,000
Springfield, Mass	19,809	13	244	....	....	......
Waltham, Mass	3,000	1	20	2	....	1,100
Worcester, Mass	....	16	437	16	775	1,300
Detroit, Mich	....	90	....	90	†	†
Saginaw, Mich	4,619	2	29	2	950	......
Duluth, Minn	....	13	232	13	1,000	1,500
Minneapolis, Minn	45,200	14	210	14	....	......
St. Paul, Minn	27,800	15	205	15	800	1,300
Kansas City, Mo	42,000	8	118	8	925	1,700
St. Louis, Mo	93,577	11	471	25	‡	‡
Butte, Mont	....	1	16	1	....	1,800
Omaha, Neb	26,000	9	140	10	900	1,400
Manchester, N. H	7,000	3	122	3	625	1,000
Bayonne, N. J	9,480	6	118	7	800	2,000
East Orange, N. J	6,246	4	70	4	900	1,500
Elizabeth, N. J	....	2	....	2	....	1,056
Jersey City, N. J	38,276	12	152	13	1,100	1,700
Newark, N. J	69,986	26	400	28	1,000	1,700
Passaic, N. J	10,070	5	75	5	1,250	1,400
Patterson, N. J	20,000	7	105	7	1,450	1,500
Plainfield, N. J	4,300	6	90	6	900	1,700

* Same as salary of regular grade teacher

§ A special school

† Twenty dollars per month above salary of regular grade teacher

Table IV—Special classes in public schools of cities reporting, and salaries of teachers for the year 1919-1920—Concluded

CITIES	Pupils in school excluding high schools	SPECIAL CLASSES			SALARIES of TEACHERS	
		Number	Number of pupils	Number of teachers	Minimum	Maximum
Trenton, N. J	15,202	14	202	14	700	1,100
Albany, N. Y	10,000	10	184	......	900	1,150
Auburn, N. Y	3,793	4	51	4	750	1,050
Buffalo, N. Y	52,912	18	....	18	1,000	1,500
Dunkirk, N. Y	2,600	2	32	2	850	950
Elmira, N. Y	4,320	4	60	4	900	1,150
Freeport, N. Y	1,400	1	16	1	....	1,100
Haverstraw, N. Y	700	1	16	1	1,020	......
Hudson Falls, N. Y	1,000	1	40	1	850	850
Ithaca, N. Y	2,083	5	75	5	....	......
Jamestown, N. Y	5,858	3	50	3	720	1,140
Lockport, N. Y	2,750	2	30	2	850	1,200
Mechanicsville, N. Y	1,880	1	17	1	950	......
Medina, N. Y	800	1	15	1	1,000	1,500
Newark, N. Y	1,000	1	11	1	....	......
New York City	747,369	241	4,129	241	1,040	2,020
N. Tonawanda, N. Y	1,762	1	15	1	....	......
Nyack, N. Y	....	2	35	2	1,000	......
Ogdensburg, N. Y	1,486	1	14	1	750	......
Ossining, N. Y	1,370	1	15	1	1,150	......
Oswego, N. Y	2,300	3	45	3	700	750
Port Chester, N. Y	3,200	1	20	1	1,000	......
Rochester, N. Y	30,000	36	550	36	900	1,700
Rome, N. Y	3,300	2	36	2	800	1,050
Schenectady, N. Y	....	4	....	4	....	1,300
Solvay, N. Y	1,250	1	....	1	900	1,000
Syracuse, N. Y	18,600	2	27	2	1,300	......
Troy, N. Y	6,200	3	46	3	900	1,200
Utica, N. Y	12,980	9	135	9	850	1,450
Watertown, N. Y	5,556	4	60	4	650	800
White Plains, N. Y	3,297	1	24	2	950	1,150
Cincinnati, O	48,738	20	400	20	950	1,700
Cleveland, O	99,539	66	1,239	66	700	1,200
Columbus, O	21,191	9	141	9	1,050	1,650
Dayton, O	15,860	3	42	3	1,400	1,600
Toledo, O	27,229	22	325	22	950	1,600
Youngstown, O	20,961	4	60	4	1,050	1,450
Oklahoma City, Okla	16,000	1	40	2	....	......
Portland, Ore	36,163	§	208	13	800	1,300
Allentown, Pa	9,905	1	16	1	....	......
Harrisburg, Pa	....	3	60	3	....	1,200
Johnstown, Pa	7,858	8	141	8	....	1,150
Philadelphia, Pa	304,415	97	1,987	97	1,000	1,440
Reading, Pa	13,908	3	49	3	800	950
Scranton, Pa	20,000	2	30	2	750	1,200
Wilkes Barre, Pa	11,051	2	....	2	....	900
Providence, R. I	34,261	17	286	17	810	1,025
Charleston, S. C	....	1	14	1	....	......
Dallas, Tex	....	2	24	2	1,300	......
Houston, Tex	22,000	2	40	3	1,500	......
Richmond, Va	21,833	23	430	23	1,000	1,400
Everett, Wash	3,950	3	30	3	900	1,560
Seattle, Wash	39,803	15	312	19	....	1,800
Milwaukee, Wis	49,129	6	....	6	900	1,500

‡ One hundred dollars above salary of regular grade teacher

Special Class Teachers

The first and most important requisite for meeting the needs of the defective children in the public-school system is the selection of properly qualified teachers. As Goddard has said in regard to special-class teachers: "Nowhere are good teachers so valuable and nowhere is the poor teacher such an utter failure and capable of doing so much harm."

Special training in the psychology of mental deficiency is necessary to enable the teacher to appreciate the minds of these children. Association with them, living for a period in schools for the feebleminded, is most desirable. Only the teacher who knows and understands the defective child, who has studied the theoretical side of the problem, who is acquainted with the history of the development of the physiological, the psychological, the pedagogical methods used in instructing defectives, and who has lived and worked with them can be said to be trained for special-class teaching.

Table IV shows that there are 1,292 special-class teachers in these 108 cities. In 53 cities special training is required of teachers doing special-class work. In 33 cities no special training is required. The teachers in these cities are selected because of "interest," "adaptability," "efficiency," etc., from the regular grade teachers.

Twenty-two cities failed to answer this question. It is interesting to note that in Cleveland, Ohio, where no special training is required, 57 of the 66 special-class teachers have had previous training in the field of mental deficiency.

It is obvious that, in order to make highly specialized training worth while, special-class teachers must receive salaries commensurate with the training and service required. The above table shows that $900 is the most frequent minimum salary for special-class teachers, although the range is from $720 to $1,500. Twelve hundred dollars is the most frequent maximum for special-class teachers, although the range is from $750 to $2,200. Sixteen hundred dollars is the most frequent minimum for supervisors of special classes, although the range is from $850 to $5,400. Twenty-five hundred is the most frequent maximum for supervisors of special classes, although the range is from $875 to $5,400. These salaries have, no doubt, been increased proportionately to the general increase in teachers' salaries that has taken place since 1919.

The greatest outstanding need at present in the matter of teachers is for training courses in normal schools and in universities, with practical work in state institutions for the feebleminded. The demand for specially trained teachers far exceeds the supply. Unfortunately there are only a very few places in the United States at the present time where teachers can receive anything like an adequate training for this work. The state institutions for the feebleminded should be model training schools for special-class teachers, but the present survey of state institutions would lead us to conclude that what they are doing in this direction is almost negligible.

Organization and Equipment of Special Classes

It is generally agreed by all who have given much thought to the subject that the defective child should not be placed in separate classes in the regular schools. Special schools should be established, and in these schools all the defective children within the area served by the school system of the district should be segregated during school hours. In this way the defective child is saved comparison with normal children. He is free from the taunts of others more capable than he and daily associates in play, as well as in work, with those of his kind. The actual school work can be better graded, better organized and systematized. Each teacher can specialize in her own line and far better results can be obtained than when each teacher has to teach every subject in the curriculum.

This study shows that 28 cities, or about 20 per cent of the total number studied, are equipped with special schools or centers, in which buildings are grouped all of the special classes within the city. Such arrangements as transportation and the like are provided by the city. The great advantage of having centered all of the school activities in behalf of the defective children of the city under the direction of highly trained teachers and expert supervisors cannot be overestimated.

It is believed that the size of the class should not exceed 15 pupils per teacher. This study shows that 27 cities had 15 pupils to a class, 14 cities had 16 to a class, 8 cities had 18 pupils to a class, 9 cities had 20 pupils, 2 cities had 25 pupils. The average number of pupils to each class is 16. The minimum per class was 7, the maximum was 41. St. Paul has 41 pupils to a class, and Oklahoma City has 40 to a class.

The importance of distinguishing between the "special class" and the "ungraded class" needs to be stressed. These two types of classes are quite distinct in purpose and method. A child may be backward because of language difficulties, ill health, physical defects, insufficient nourishment, irregular school attendance, or for many other reasons. Proper study and treatment of the causes underlying this backwardness usually serve to return the child to the regular grade. It is for this type of pupils that the ungraded classes are created. On the other hand, the special-class child is a wholly different problem. He is feebleminded, and because of this fact will never under any conditions be able to keep step with the rank and file of school children. The methods necessary to fit him for usefulness in the community are along entirely different lines from those suited to the average "backward" school child. Placing the two together in the same class is an injustice both to the backward and to the feebleminded child. A distinction is made between the special and the ungraded classes in 66 cities, whereas in 35 cities, or 32 per cent of the 108 cities studied, no distinction whatever is made. In 7 cities no answer is made to this question. It is therefore quite likely that many of the special classes represented in this report contain backward children as well as feebleminded.

The organization of these special schools calls for three departments: (1) the kindergarten, in which the children are of the mentality of two, three, or four years; (2) the departmental division, in which the children are of the mentality of five, six, seven, eight, and nine years; and (3) the vocational or trade classes. The subjects that are taught in these various groups are about the same and are adapted to the mentality of the children in the several departments, just as arithmetic is found in the different grades in the regular school.

Selection of Special-Class Pupils: Mental Clinics

One of the purposes of the survey was to ascertain the methods being used by the cities studied in selecting from the schools the pupils for the special class, or, in other words, the criteria being used for the diagnosis of mental deficiency. It is doubtless unnecessary to emphasize the fact that all serious-minded students of mental deficiency deplore the hasty, superficial methods employed by untrained persons, who, armed with a set of Binet tests, plus a few weeks' training in abnormal psychology, pose before school authorities as diagnosticians of mental defect.

Mental tests in the hands of a skilled psychologist who has had adequate laboratory training and ample clinical experience are of immense value in gathering essential data that are to be used in the final diagnosis of the individual child. These tests do not give, however, all of the facts in the case, and sometimes not even the most important facts are thus obtained.

The mental diagnosis of the individual child, the recognition of mental defect as against epilepsy or psychopathic personality or incipient mental disease, is a very complex matter, requiring not only a training in general medicine and in normal psychology, but a highly specialized training in the field of psychiatry.

This investigation shows that 16 of the 108 cities that replied to the questionnaire had no examinations whatever, the children being selected by teachers and principal purely on the basis of school work in the regular grades; that in 54 cities, or about 54 per cent of the total number, special-class teachers, principals, and supervisors gave Binet tests and made diagnoses upon children selected by the grade teachers. With no examination other than these tests, a child is diagnosed as defective or not defective. In 36, or 32 per cent, of the cities studied, psychiatrists or psychologists passed upon the question of mental condition before the child was placed in the special class. In 3 cities trained nurses gave Binet tests.

The following list shows the cities that regard the diagnosis of mental deficiency and other abnormal mental conditions among their school children of sufficient importance either to employ for this purpose specially trained people—psychiatrists and psychologists—or to utilize existing mental clinics within the city or state:

Birmingham, Ala.
Los Angeles, Cal.
Oakland, Cal.
San Diego, Cal.
Denver, Colo.
Washington, D. C.
Chicago, Ill.
Des Moines, Ia.
Louisville, Ky.
Boston, Mass.
Haverhill, Mass.
New Bedford, Mass.
Springfield, Mass.
Worcester, Mass.
Detroit, Mich.
St. Paul, Minn.
St. Louis, Mo.
Newark, N. J.
Trenton, N. J.
Albany, N. Y.
Buffalo, N. Y.
Ithaca, N. Y.
Newark, N. Y.
New York, N. Y.
Nyack, N. Y.
Ossining, N. Y.
Rochester, N. Y.
Schenectady, N. Y.
Syracuse, N. Y.
Watertown, N. Y.
Cincinnati, Ohio.
Cleveland, Ohio.
Youngstown, Ohio.
Providence, R. I.
Richmond, Va.
Milwaukee, Wis.

In 68 per cent of these 108 cities, children were being placed in special classes for mental defectives without being properly diagnosed by adequately trained experts. As we have indicated above, so many factors enter into the diagnosis of mental deficiency other than the pure question of mental level and intelligence quotient—questions having to do with endocrine conditions, congenital and acquired syphilis, epilepsy, and many other general medical, neurological, and psychiatric problems—that the wholesale diagnosis of mental deficiency by means of mental tests alone would be merely ludicrous were not the fact of its being daily a practice throughout the United States so serious as to warrant grave consideration.

The rapid development of mental clinics in almost all of the larger cities of the country, as well as the growing tendency of state hospitals, state institutions for the feebleminded, and local psychopathic hospitals to create out-patient clinics, promises soon to furnish ample facilities for the careful examination and diagnosis of all mentally defective children in the public schools of the larger cities. School authorities should be urged to utilize these clinics or, in the very large cities, develop their own school clinics with well trained psychiatrists in charge. The present methods of health examination of school children could easily be extended so as to insure and require a careful mental examination of every child obviously retarded in school work. Rural communities and small towns could be served by a traveling mental clinic from the state institution for the feebleminded.

The determination that a child is a proper subject for a special class is of serious consequence to its future welfare. If the decision is correct, it means an opportunity partially to overcome his prodigious handicap. But no greater injustice can be done a child than to class him as feebleminded and at a critical period in his life surround him with feebleminded children when the difficulty is but a temporary retardation in his mental processes which will disappear with the treatment of his physical disabilities and the removal of such other causes of his mental backwardness as may be found.

Training of Special-Class Pupils

As we have indicated in our discussion of the curricula and methods of training feebleminded children in state institutions, the defective child is unable to assimilate the generalized academic training given in the regular grades. The English Commission on The Care and Control of the Feebleminded reports: "Schooling in personal habits was found to be the first step in the education of the defective. Then more and more it was evident that the intelligence was aroused through the hands and eyes working together in making or doing some actual thing, rather than by the secondary and more abstract accomplishments of reading, writing, and arithmetic. This suggested great changes in teaching, and now in the opinion of many the simple occupations of the earliest years of schooling should develop into systematic industrial training, while the scholastic teaching should become entirely subordinate and, indeed, in some cases be entirely discontinued."

Industrial and vocational training is the only means of turning these unfortunate children to practical account. Those subjects which are usually included in the courses of study for the defective classes of the public schools are practically the same as we have mentioned in our discussion of training in institutions for the feebleminded. They include habits of personal cleanliness, sense training, physical training, vocational and industrial training, gardening, academic work, and speech training.

The type of training given in the special classes in the 108 cities studied is as follows:

Types of training	Cities
Manual and industrial training only	8
Regular grade work only	5
Combination of regular grade work, manual, and industrial training	75
No regular scheduled methods of training, leaving question to each individual teacher	17
No reply to this question	3
Total	108

All who have given much thought to defective children emphasize the great value of physical training, yet only 18 out of the 108 cities reported that they were giving any attention to physical training.

Again reverting to the value of industrial training, the replies show the following as to equipment along these lines:

	Cities
Well equipped with facilities for manual and industrial training	50
Fairly well equipped	31
Poorly equipped	10
No equipment	17
Total	108

The classes of 75 per cent of the cities reporting are either well or fairly well equipped for manual and industrial training, while 25 per cent are either poorly equipped or have no equipment at all. These latter might well be included in the "opportunity classes" so aptly referred to by Doctor Porteus when he says, "The children in certain special classes may rightly be regarded as being in an 'opportunity class.' They allow the ordinary grade teacher an opportunity to do better work without them."

The greatest criticism we have to offer from a careful study of the returns of the questionnaire is that school authorities all too frequently see in the special class only a chance to segregate a greater or less number of children from the regular grades; to remove from the wheels of the educational machine a certain amount of grit that disturbs the smoothness of its running gear. Too often it was obvious that there was little or no purpose in view in the training given. Weeks and months of a defective child's time might be taken up in the making of a basket or the weaving of a rug, or in doing many things that would never lead to self-support. To be sure, these kept the child employed, provided good exhibit material, and relieved the teacher of the necessity of much planning; but as for fitting the child to do some useful thing by means of which he could earn a living, that was a consideration that apparently had received very little thought and attention in the majority of instances.

Supervision of Special-Class Pupils

The part the public-school system through special-class instruction is to play in enabling the state to meet and solve the problem of mental deficiency is to a great extent to be measured by the degree of after-care work and supervision that is to be given these children, not only during the period marked by their years of training in the special classes, but after they have left the school and become a part of the industrial and social life of the community.

We must remember that the mentally defective child will always be a defective. No amount of training will ever make him a skilled workman or ever enable him to direct his affairs with good judgment, common prudence, and reasonable foresight. If, during a few hours of the day, over a few years of childhood, a certain amount of academic and manual training is given him—a little needlework, basketry, weaving, gardening, etc.—and all of a sudden, at the age of 14, 15, or 16, the most dangerous period of his life from a social point of view, he is dumped, unguided, and unsupervised, out into the community to earn a living, can we be surprised later at his shipwreck? In fact, one is prepared to doubt in all seriousness whether it is worth while to have special classes, whether all of the patient and earnest efforts of the several hundred splendid special-class teachers in the long run is going to pay, if there is no organized and systematic follow-up work of the defective pupils.

This study shows that in 26 cities, or 24 per cent of the total number included in the investigation, supervision and after-care work are being given the defective pupils during the period of their attendance in public school. This is done altogether by the special-class teachers themselves, and is usually a voluntary matter. In a few cities there is an attempt at a definite organization for after-care work. In 82 cities, or 76 per cent of those studied, there is no after-care work of any character. In only 5 cities, Milwaukee, St. Paul, Seattle, Charleston, and Schenectady, was anything like a serious effort being made to keep in touch with the defective children after they had left school and entered employment. Since this questionnaire was sent out, Cincinnati has begun an organization of after-care work of its defective children.

The blame for the failure to meet this important problem of supervision is not to be laid at the door of the special-class teachers. Supervision is certainly not one of their responsibilities. They have all and more than they can do as it is. Some constituted state authority should be charged with the lifelong supervision of all mental defectives who need such care. The public needs to be awakened to the fact that the responsibility for meeting this, the largest problem presented by the defective, cannot be shifted to the shoulders of the special-class teacher.

Conclusion

We are now passing through a period marked by a slow and gradual, but none the less sure and fundamental, change in our whole attitude towards the problem of mental deficiency. The dominant note of the state institution is becoming less and less custodial and more and more medical and educational. There is less and less of the atmosphere of the poorhouse, and more and more that of the hospital and training school. We are thinking more in terms of a sensible, statewide program for handling in some way every mental defective in the state, and for fitting as many as possible for safe supervision on parole in the community, as contrasted with the policy of segregating in some isolated spot a few custodial cases, and leaving the educable defectives to become juvenile delinquents, adult criminals, vagrants, prostitutes, dependents, and paupers.

It was obvious from this study that many states are as yet unaware of this change, or at least fail to appreciate its significance. In some institutions little or no educational work was being given. In the great majority, such work as was given was without any very definite end in view other than to make some of the children useful around the institution, or to teach a few how to read and to write, to provide exhibit material for visitors and fairs, or to give regular grade work simply because some sort of schooling was supposed to be given.

Each institution seemed to be a unit revolving on its own axis, separate and distinct from all other agencies in the state. The conception of the state institution as the center around which would revolve the entire machinery of the state for the handling of mental deficiency, for intensively training educable defectives and fitting them with trades for useful lives under supervision in the community, for carefully preparing the special-class teachers of the public schools within the state, for conducting mental clinics for these schools, for carrying on research into the causes, distribution, social significance, and treatment of mental deficiency, for educating medical men in the methods of diagnosis, etc., has as yet made little headway. Some of our institutions are fully awake to the importance and possibilities in this direction, but with two or three notable exceptions they have as yet been unable to get under way the machinery for carrying into effect any part of the above program.

The army figures as reported by Colonel Pearce Bailey[1] indicate that there was a ratio of 6.5 defectives for every one thousand men examined. Inasmuch as there were 10,101,506 registrants between the ages of twenty-one and thirty-one years, this ratio would give for the entire number registered 65,650 male mental defectives of the given age period. To quote from Colonel Bailey's report, "If mental deficiency ran uniform among persons of all ages, there would be 353,210 male defectives in the United States." If there are as many female defectives, we would have above 700,000 mental defectives in this country. Approximately 40,000 are being cared for in state institutions for the feebleminded, or, in other words, about 6 per cent of the entire number.

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[1] *Mental Deficiency: Its Frequency and Characteristics in the United States as Determined by the Examination of Recruits*, by Pearce Bailey and Roy Haber. MENTAL HYGIENE, Vol. IV, pp. 564-604, July, 1920.

Colonel Bailey, using the army figures, says: "Mental defect is approximately ten times more frequent than drug inebriety or disabling alcoholism, although about one of these terrors the press keeps constantly informing us, and to prevent the other our federal Constitution has been amended; it is three times more frequent than insanity, in provision for which there is a general quickening of interest throughout the country, and for the cure of which at least half a dozen of our states have developed systems of the highest order of merit."

In only a few states has the problem of mental deficiency been considered with any degree of intelligence or foresight by legislators, while it has been almost totally neglected by the federal government.

By far the most outstanding need at the present time, that which transcends all others in importance, is for greatly increased institutional provision. There are still five states that have no separate provision for the mentally defective. The great majority of states are caring for only a few hundred in institutions inadequately equipped for the large problems they have to meet, while in no state are there under way plans sufficiently comprehensive in nature to enable the state to provide institutional care for even those most urgently in need of it.

Adequate institutional provision for all mental defectives is impossible in the present state of public sentiment. Such training as the great majority will receive will be in the public schools. The public schools of the country have not yet taken up this question seriously. In a few cities there are dotted here and there special classes for a few mentally defective children. But there is absolutely no consideration whatever given to the defective children found in the rural and village schools; and yet the army figures showed that two-thirds of the cases of mental deficiency came from rural districts.

In summary, a program adequate for the immediate needs of the situation may be stated as follows: first, greatly increased institutional provision; second, the proper equipment of every institution for the adequate and purposeful training of all children capable of profiting by such training; third, proper provision for parole under careful supervision of all mental defectives who can be handled satisfactorily in the community; fourth, mental examination by properly equipped experts of all defective children in the public schools (machinery already existing in the state can often be utilized for this purpose); fifth, special-class provision for every defective school child in the community capable of profiting in such classes, these classes to be well equipped along physical training, manual, and industrial lines, and seriously charged with the duty of fitting the defective child for a safe and useful life in society; sixth, after-care — kindly and friendly supervision of all mental defectives.

DECLINE OF ALCOHOL AND DRUGS AS CAUSES OF MENTAL DISEASE

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Statistician, New York State Hospital Commission

WHAT has been the effect of the Prohibition Amendment on insanity in New York State? Has the number of alcoholic cases admitted to the state hospitals for mental disease decreased in recent years? Is the number of new cases of drug insanity increasing?

The Bureau of Statistics of the State Hospital Commission has received a statistical card for each patient admitted to the thirteen civil state hospitals for mental diseases since October 1, 1908. Among other things this card contains data concerning the form and causes of the mental disease of the patient, and a statement of his habits with respect to the use of alcohol and drugs. The patients admitted for the first time to any hospital for the treatment of mental disease are called *first admissions,* and those admitted who have previously been patients in institutions for mental cases are called *readmissions.* As the annual rate of first admissions shows better than any other data the incidence of mental disease, the readmissions are not included in this study.

During the twelve fiscal years from October 1, 1908 to June 30, 1920, the civil state hospitals received 72,699 first admissions, of which 38,147 were males and 34,552 were females. The total first admissions of each year and the number of cases of alcoholic and drug insanity among them are shown in Table 1.

Referring to Table 1, we note that the number of first admissions increased each year from 1909 to 1914. In 1915 there was a slight decrease. In 1916 the fiscal year was changed so that it ended on June 30, instead of September 30; the 1916 statistics therefore cover but 9 months. In 1917 a remarkable increase in first admissions took place, due probably to the great emotional disturbances accompanying the entrance of the United States into the World War. In 1918 and in 1919 a slight drop in the number of first admissions occurred and in 1920 the decline was more marked.

TABLE 1. ALCOHOLIC AND DRUG CASES AMONG FIRST ADMISSIONS TO THE CIVIL STATE HOSPITALS FOR THE INSANE, 1909-1920

YEAR	TOTAL FIRST ADMISSIONS			ALCOHOLIC PSYCHOSES						DRUG PSYCHOSES					
				NUMBER			PER CENT			NUMBER			PER CENT		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
1909.........	2,780	2,442	5,222	433	128	561	15.6	5.3	10.8	8	16	24	0.3	0.7	0.5
1910.........	2,957	2,607	5,564	452	131	583	15.3	5.0	10.5	10	12	22	0.3	0.5	0.4
1911.........	3,013	2,687	5,700	444	147	591	14.7	5.5	10.4	13	8	21	0.4	0.3	0.4
1912.........	3,010	2,732	5,742	434	131	565	14.4	4.8	9.8	7	11	18	0.2	0.4	0.3
1913.........	3,191	2,870	6,061	438	134	572	13.7	4.7	9.4	10	11	21	0.3	0.4	0.3
1914.........	3,338	2,927	6,265	348	116	464	10.4	3.6	7.4	19	17	36	0.6	0.6	0.6
1915.........	3,260	2,944	6,204	255	90	345	7.8	3.1	5.6	12	12	24	0.4	0.4	0.4
1916 (9 mos.) .	2,572	2,331	4,903	215	82	297	8.4	3.5	6.1	6	8	14	0.2	0.3	0.3
1917.........	3,605	3,272	6,877	437	157	594	12.1	4.8	8.6	3	5	8	0.1	0.2	0.1
1918.........	3,530	3,267	6,797	257	97	354	7.3	3.0	5.2	7	12	19	0.2	0.4	0.3
1919.........	3,527	3,264	6,791	204	65	269	5.8	2.0	4.0	5	11	16	0.1	0.3	0.2
1920.........	3,364	3,209	6,573	90	32	122	2.7	1.0	1.9	3	8	11	0.1	0.2	0.2
Total........	38,147	34,552	72,699	4,007	1,310	5,317	10.5	3.8	7.3	103	131	234	0.3	0.4	0.3

The completion of the Federal census of 1920 enables us to compute for the several years the rate of first admissions per 100,000 of the general population of the state. Such rates are shown in Table 2.

TABLE 2. RATE PER 100,000 OF GENERAL POPULATION OF ALL FIRST ADMISSIONS TO THE CIVIL STATE HOSPITALS FOR THE INSANE, 1909-1920

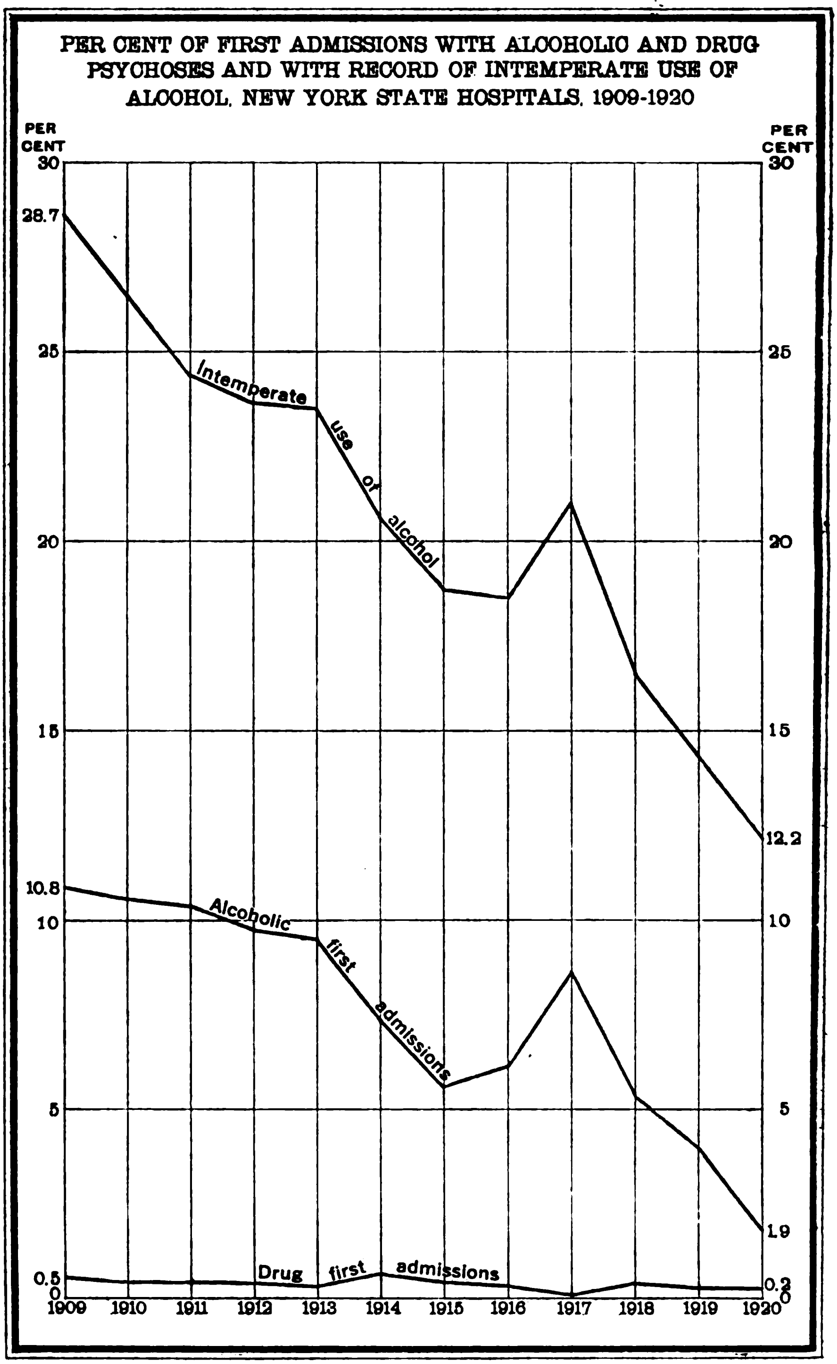
Year	Total first admissions	Rate per 100,000 of general population
1909	5222	58.6
1910	5564	61.0
1911	5700	61.8
1912	5742	61.5
1913	6061	64.1
1914	6265	65.4
1915	6204	64.0
1916 (9 mos.)	4903	66.5*
1917	6877	69.0
1918	6797	67.3
1919	6791	66.3
1920	6573	63.3

* Reduced to yearly basis.

The decline in the rate of first admissions during the past year is very significant. From it we catch a gleam of hope that the heavy burden of mental diseases now resting on the people of the state may gradually become lighter.

The excessive use of alcohol may cause the forms of mental disease known as the alcoholic psychoses or be a precipitating factor of other forms of mental disease. The alcoholic psychoses form a distinct group in the standard classification of mental diseases and the diagnosis of the cases does not present great difficulty. It may be safely assumed, therefore, that practically the same standards have been applied in filling out the statistical cards from year to year.

Table 1 gives, by sex, the number and percentage of cases of alcoholic psychoses among first admissions to the civil state hospitals each year from 1909 to 1920. The total alcoholic



PER CENT OF FIRST ADMISSIONS WITH ALCOHOLIC AND DRUG PSYCHOSES AND WITH RECORD OF INTEMPERATE USE OF ALCOHOL, NEW YORK STATE HOSPITALS, 1909-1920 first admissions during the twelve fiscal years were 5,317, of which 4,007 were males and 1,310, females. During the five fiscal years, 1909 to 1913, inclusive, the annual number of alcoholic cases averaged 574 and varied but little. In 1914 there was a marked drop in the number and this was followed by another drop in 1915. In 1917 a marked increase occurred, but this was followed by a rapid decline until, in 1920, the total alcoholic first admissions numbered only 122. The percentage of alcoholic cases among first admissions dropped from 10.8 in 1909 to 1.9 in 1920.

The annual rates of alcoholic first admissions per 100,000 of the general population are shown in Table 3.

TABLE 3. RATE OF ALCOHOLIC FIRST ADMISSIONS TO THE CIVIL STATE HOSPITALS FOR THE INSANE PER 100,000 OF THE GENERAL POPULATION OF THE STATE, 1909-1920

Year	Number	Rate per 100,000 of general population
1909	561	6.3
1910	583	6.4
1911	591	6.4
1912	565	6.0
1913	572	6.0
1914	464	4.8
1915	345	3.6
1916	297	4.0*
1917	594	6.0
1918	354	3.5
1919	269	2.6
1920	122	1.2

* Reduced to yearly basis.

It will be noted that the rate of alcoholic first admissions per 100,000 of the general population declined from 6.4 in 1910 to 1.2 in 1920.

INTEMPERATE USE OF ALCOHOL

If the facts concerning the decrease in alcoholic mental disease stood alone, they might be interpreted as being due to changes in diagnosis rather than to changes in the use or influence of alcohol. Additional light is thrown on the matter by the record of the intemperate use of alcohol by first admissions prior to the onset of the mental disease. The facts relative to such use are shown in Table 4.

TABLE 4. INTEMPERATE USERS OF ALCOHOL AMONG FIRST ADMISSIONS, 1909-1920

Fiscal year ending	Number Males	Females	Total	Per cent of total first admissions Males	Females	Total
1909....	1,229	369	1,598	44.2	15.1	28.7
1910....	1,684*	488*	2,172*	56.9	28.7	38.1
1911....	1,082	302	1,384	35.9	11.2	24.3
1912....	1,097	273	1,370	36.5	10.0	23.8
1913....	1,103	318	1,421	34.6	11.1	23.5
1914....	1,027	258	1,285	30.8	8.8	20.5
1915....	939	225	1,164	28.8	7.5	18.7
1916....	725	182	907	28.2	7.8	18.5
1917....	1,152	300	1,452	32.0	9.2	21.1
1918....	851	253	1,104	24.1	7.7	16.2
1919....	804	161	965	22.8	4.9	14.2
1920....	684	119	803	20.3	3.7	12.2
	12,377	3,248	15,625	32.5	9.4	21.4

* Includes moderate drinkers.

It appears that of the first admissions of 1909, 44.2 per cent of the males and 15.1 per cent of the females were intemperate users of alcohol. In 1910 the moderate drinkers were included with the intemperate in the tabulation, but for subsequent periods the figures show a marked decline in the percentage of intemperate users, until, in 1920, only 20.3 per cent of the males and 3.7 per cent of the females were reported in the intemperate group.

In considering these facts in connection with the Prohibtion Amendment it should be remembered that the amendment was in force for only five and one-half months of the fiscal year that ended on June 30, 1920. Of the 122 new cases of alcoholic mental disease admitted to the civil state hospitals during the year, 75 reached the hospitals before January 16, 1920, and 47 after that date. As nearly all forms of alcoholic mental disease result from long continued and excessive use of alcohol, it would be expected that some cases would develop after the public sale of intoxicating liquors ceased. The great reduction in the rate of admissions of new alcoholic cases since the amendment went into effect indicates that excessive drinking has been much lessened, if not entirely stopped.

In this connection it should be remembered that for several years prior to the passage of the Prohibition Amendment there had been a gradual decline in excessive drinking and that during the greater part of the war traffic in distilled liquors was forbidden.

Mental Disease Due to Drugs

It was feared by many that the discontinuance of the public sale of alcohol as a beverage would result in increased indulgence in the use of narcotic drugs and that the number of cases of mental disease due to such drugs would greatly increase. By referring to Table 1, we find that the drug cases among first admissions have declined rather than increased during the past year.

Drugs have never been prominent among the causes of insanity in this state. The highest number of drug first admissions to the civil state hospitals recorded in any one of the past twelve years was 36, in 1914. These constituted about 0.6 per cent of the total first admissions. Since 1914 the annual number of drug cases has declined, there being but 11, or less than 0.2 per cent of all first admissions, in 1920.

Conclusions

1. The annual rate of the incidence of mental disease in New York State has decreased since 1917.
2. The annual rate of admissions of new cases of alcoholic mental disease to the civil state hospitals has greatly declined in recent years and reached its lowest point in 1920.
3. The percentage of first admissions with a history of intemperate use of alcohol has declined since 1917 and was lowest in 1920.
4. The annual rate of new cases of drug insanity admitted to the civil state hospitals has declined in recent years.

AN EXPERIMENT IN LIBRARY WORK IN A HOSPITAL FOR MENTAL DISEASE

RUTH BRADLEY DRAKE
A. L. A. Librarian, St. Elizabeths Hospital, Washington

MANY know of the work accomplished by the American Library Association during the war—of the camp libraries that came into existence almost simultaneously with the erection of the various military cantonments whose doors welcomed eager readers from early morning until "taps" were sounded; of the books on the transports that cheered our men not only on their way to battle, but also on the homeward journey, helping to speed away what otherwise might have been dull hours of waiting; of the A. L. A. Headquarters at Paris, which was the center of our library activities abroad, serving men not only at the front, but *en repos.*

They may know, also, of an important phase of this work that was undertaken early in 1918, to serve men, weak in body and spirit, whose health had been broken either before entering upon their duties on the firing line or as a result of wounds and injuries received in battle. They can picture the hospital librarian wheeling her book cart through the wards of her hospital to the bedside of each patient able to read, cheering him on his road to recovery with her "wares," which consisted, not only of books, magazines, papers, pictures, and scrapbooks, but also of a word of cheer or a story to help brighten the day. Nor did she leave the ward without paying her respects to the medical officer in charge, who, perhaps, desired books of a scientific or recreational nature, and a glance at the morning paper; or the nurse, who wanted a novel or a magazine to read in her spare moments; or the faithful corpsman, who, when his duties were completed, liked to improve his time by reading or studying books relating to his vocation instead of sitting at his desk with arms folded. Patients, doctors, nurses, and corpsmen were served alike by the "Book Sister," as she was invariably called.

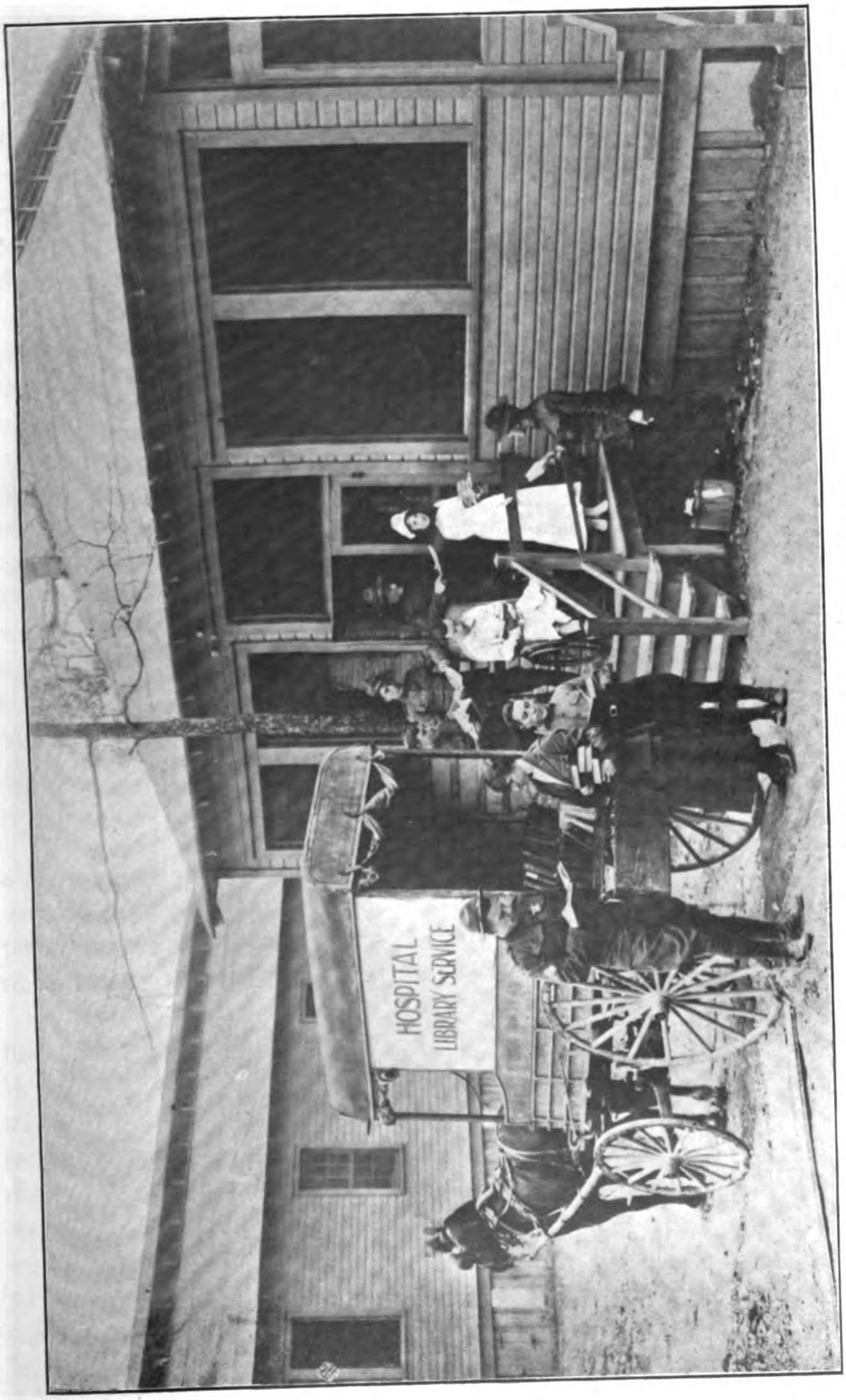
Hospital librarians were sent to general hospitals, which cared for the ordinary medical and surgical cases of each cantonment, to special hospitals for the tuberculous, to hospitals that served those blinded in battle, and to orthopedic hospitals for surgical cases that required prolonged treatment of a nature too specialized to be treated in the general hospitals. It may not be so generally appreciated, however, to what extent book service was carried on by the American Library Association in hospitals that specialized in nervous and mental diseases. Hospital librarians were there also to serve perhaps the most unfortunate of all our service men—those soldiers, sailors, and marines who were broken mentally as well as physically. Librarians were not only assigned to hospitals caring for acute psychopathic patients, but were on duty also in one of the largest institutions in the country that cares for those most severely afflicted—the insane. St. Elizabeths Hospital, the 3,700-bed Government Hospital for the Insane, at Washington, D. C., received, during the war, such nervous and mental cases among our service men as required prolonged and special treatment, and to this institution many men were transferred from camp hospitals. Soon after their arrival, a call came from A. L. A. service, and I was fortunate enough to be assigned to duty there. A few of my personal experiences may be worth relating to emphasize the value of book service for the mentally ill, not only from a recreational, but also from a therapeutic standpoint.

A word is necessary first, however, concerning library work in psychopathic hospitals before the war. Library work among the mentally diseased had already been carried on successfully at McLean Hospital, Waverley, Massachusetts, by Miss E. Kathleen Jones, who was for several years librarian of that institution and extremely interested and efficient in that field. Good results had been obtained also by Miss Miriam Carey and Miss Julia Robinson, of Minnesota and Iowa respectively, who have long been interested in the development of institutional library work. In spite of such work as this, it was the war that really opened the eyes of librarians to what could be done for the mentally disabled.

Hospital librarians on duty in general hospitals counted among their patrons those patients who were assigned to the neuropsychiatric wards on account of acute mental illness. The interest in such patients—assumed by the librarians in spite of many difficulties, for both doctors and nurses were at first extremely skeptical as to the value of book service in their wards—and the results finally obtained, due principally to the splendid resources offered those librarians by the association, paved the way for a still further extension of the work. An experience of one of the hospital librarians, stationed in a Southern hospital, will illustrate this point. On her first visit to the neuropsychiatric wards, she was greeted not at all cordially by the medical officer and nurse in charge. Both advised her that their patients would not care to read or could not read, and that it was useless, according to their opinion, for her even to "make rounds" on those particular wards. Such rebukes, however, did not daunt her enthusiasm. She was determined to serve all alike and to give those patients a fair trial, at least. After obtaining a reluctant permission from the medical officer to visit his wards, she started forth. "Perhaps I am foolhardy, after all," was her thought as she entered the ward and was greeted by blank faces and no response to her questioning. One after another scorned her "wares," but just as she was about to leave, a call came from a patient nearby, who requested a book on salesmanship. That "broke the ice," and others began to show a willingness to accept magazines, pictures, and scrapbooks. A start, at least, had been made.

A second visit to the ward revealed the fact that the lad who had requested the book on salesmanship had actually been a salesman and wished to continue his study of the subject. From that time on, he, as well as his companions, never allowed the librarian to pass by without requesting books or other material.

On one of her visits to the same ward, a patient who had asked her to bring him the last number of the *Review of Reviews* called her back a second time, asking her to bring him also a box of gingersnaps and some cigarettes. Realizing that gingersnaps and cigarettes might help in gaining the confidence of patients, she "delivered the goods"—books, gingersnaps and cigarettes—the same afternoon. After that, whenever she approached that particular ward, she was greeted by her friend, who smilingly offered to help her distribute her books and magazines. He seemed to take a great deal of pleasure, also, in informing her of the reading capacity of his


HOSPITAL
LIBRARY SERVICE

Book delivery at Fort Oglethorpe, Georgia

Reading room, St. Elizabeths Hospital, Washington, D. C.

associates. After spending several months in that ward, he recovered sufficiently to be discharged and was able to accept a position in a small Mississippi town, evidently located far from the resources of a library. But he did not forget the hospital library, as the following extract from a letter received by the hospital librarian will testify:

> "You know I sometimes wish I were a soldier yet. As I stated before, I shall never forget Camp Greenleaf and the nice librarian lady . . . Don't suppose you could afford to send me any books now as I'm a civilian, but would like to read *When a Man's a Man.*"

Gradually the work among the nervous and mental patients increased until it equalled in magnitude that of the other hospital wards. Medical officers and nurses, once skeptical as to the value of this service, now were as eager as the patients to welcome the librarian to their wards, and more than once expressed the opinion that books actually were of therapeutic as well as of recreational value to their patients. Those of us who had experience with the nervous and mental patients in camp hospitals, and those of us who continued to work among them long enough to see results, realized that a new field of work was before us. Doors were opened to us which had never been open before, and possibilities for service presented to us that we had not even suspected.

April 1, 1919, found me journeying toward St. Elizabeths Hospital. As I walked through the beautiful grounds that balmy spring morning, receiving on every hand cheerful greetings from patients able to stroll about at their pleasure, I could scarcely imagine myself in or near an insane hospital. I wondered if the hospital authorities had ever provided a library for the use of patients who, instead of restlessly wandering about, might wish to spend their leisure time in reading. Surely, among 3,700 patients, there must be many readers. When I reached the "Center Building," so-called because it was once used as an administration building for the hospital group, my curiosity was satisfied, for I was directed to the library on the first floor of that building. Two rooms, one used as a stack room and the other for storage purposes, were filled to overflowing with books. Dignified volumes of ancient origin stood side by side on the shelves with their younger companions, whose overwhelming popularity was evidenced by their tattered and torn condition. Were these books actually read or maliciously destroyed? I was soon to see.

The library was opened two mornings a week for the use of the patients, being supervised by one of the women physicians, who was obliged to leave her own important duties for the time in order to serve as best she could the eager throng seeking books. But it was better to have such a library than no library at all and better to have such service than no service at all. The hospital authorities, handicapped by increased expenses that had to be met with limited funds, were unable to set aside a library budget sufficient to insure upkeep of the library. Owing, however, to the transfer of many military patients to the institution, the reading public had increased materially and must be served, and the hospital authorities were very glad to be relieved by the A. L. A. in the matter of book service, even if only temporarily. A nucleus of a library was there and a chance for the A. L. A. to give real service.

"Library Day" rolled around soon after my arrival. As soon as the doors were opened, in came soldiers, sailors, and marines who had served in the World War, those on parole coming at their leisure, the others being accompanied by nurses or attendants. Army and navy medical officers and their detachment men, stationed at the hospital to care for the 1,500 or more service men who were patients there, came also, all with one desire—"something to read." Civilian doctors, members of the hospital staff, as well as their wives and children, and hospital employees wished to be served too, for they were far distant from the resources of a public library. An occasional Civil or Spanish-American War veteran wandered in, for St. Elizabeths Hospital cares for the service men not only of this, but of former wars. Former government officials, and others, citizens of the District of Columbia, including men and women of many nationalities are, also, patients of this hospital. Thus the library must serve not only service men, but the entire hospital community, a veritable city in itself.

It was plain to be seen that those most eager and those best able to read could come to the library. The first and most essential task, then, was to provide a central reading room for those who desired to free themselves for the time being from the hospital atmosphere. In a few weeks the storage room was transformed. The old and worn-out volumes were replaced by new and attractive ones. The room, though located on the north side of the house and lacking the cheerfulness of sunshine, was brightened by the addition of rugs, plants, flowers, and pictures, and furnished with reading tables and comfortable chairs. Patients, doctors, nurses, detachment men, and other employees alike enjoyed this recreational center, which was open morning and afternoon daily, except Sunday. There they came and read or chatted at their leisure. Books were available for those who wanted to concentrate on them, magazines and scrapbooks for those who wished such material, and newspapers for those who desired to keep in touch daily with the outside world. The librarian's desk was placed in a corner of the stock room, which adjoined the reading room; thus she was near, yet removed from the notice of readers who might not care to be watched. Personal attention was given those who desired aid in the selection of books, and the librarian was never too busy to chat with her patrons.

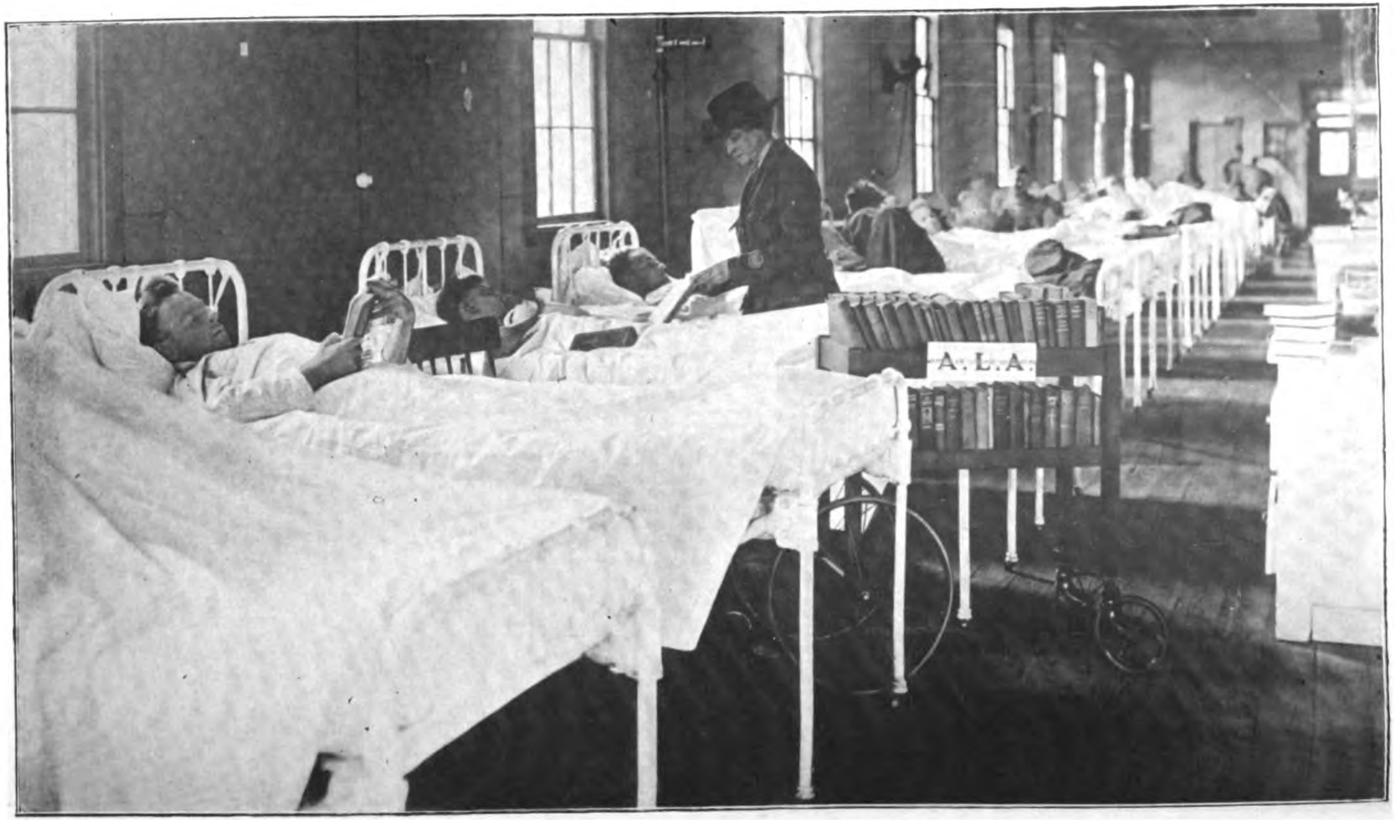
The next step was to reach patients who were too ill to come to the reading room even with their nurses. Judging from the requests brought in from the wards by nurses, many patients at times were not infrequently able to enjoy a magazine, a scrapbook, or even a book. The matter was certainly worth investigation. Leaving an assistant in charge of the reading room after the work there was well organized, I made a tour of the wards in order to find patients who were able to read. Realizing that most patients who were unable to reach the library probably would be in no condition to concentrate on books, I took magazines and scrapbooks. Sufficient time was allowed to approach each patient and to give him individual attention.

I found, after making a survey of the wards, that many of the patients were not satisfied with magazines and scrapbooks alone, but desired books. A soldier in one of the wards for epileptics, when asked what kind of reading matter he wished, replied in gruff tones that he wanted nothing in the world but his discharge papers. His head was buried in his lap, but just as I was about to leave he raised it, discovering for the first time that it was not a nurse who had addressed him, but as he thought, "a lady from Alabama." It happened that his home was in Alabama, so he immediately became interested in talking with me. After I had explained the meaning and purpose of the A. L. A., he produced from his pocket a notebook, asking me to observe what he had been doing to amuse himself during his leisure hours. The pages were filled with designs and lettering of various kinds. I discovered during my conversation with him that his pre-war occupation had been that of draftsman. He was surprised to learn that the libarary contained books on this subject, and when he received one, that same afternoon, I am sure he did not have much time to fret about his discharge. After studying that special book for over a week, he requested more, thus occupying his time advantageously. It was much pleasanter, upon entering his ward, to see him reading rather than with his head buried in his lap.

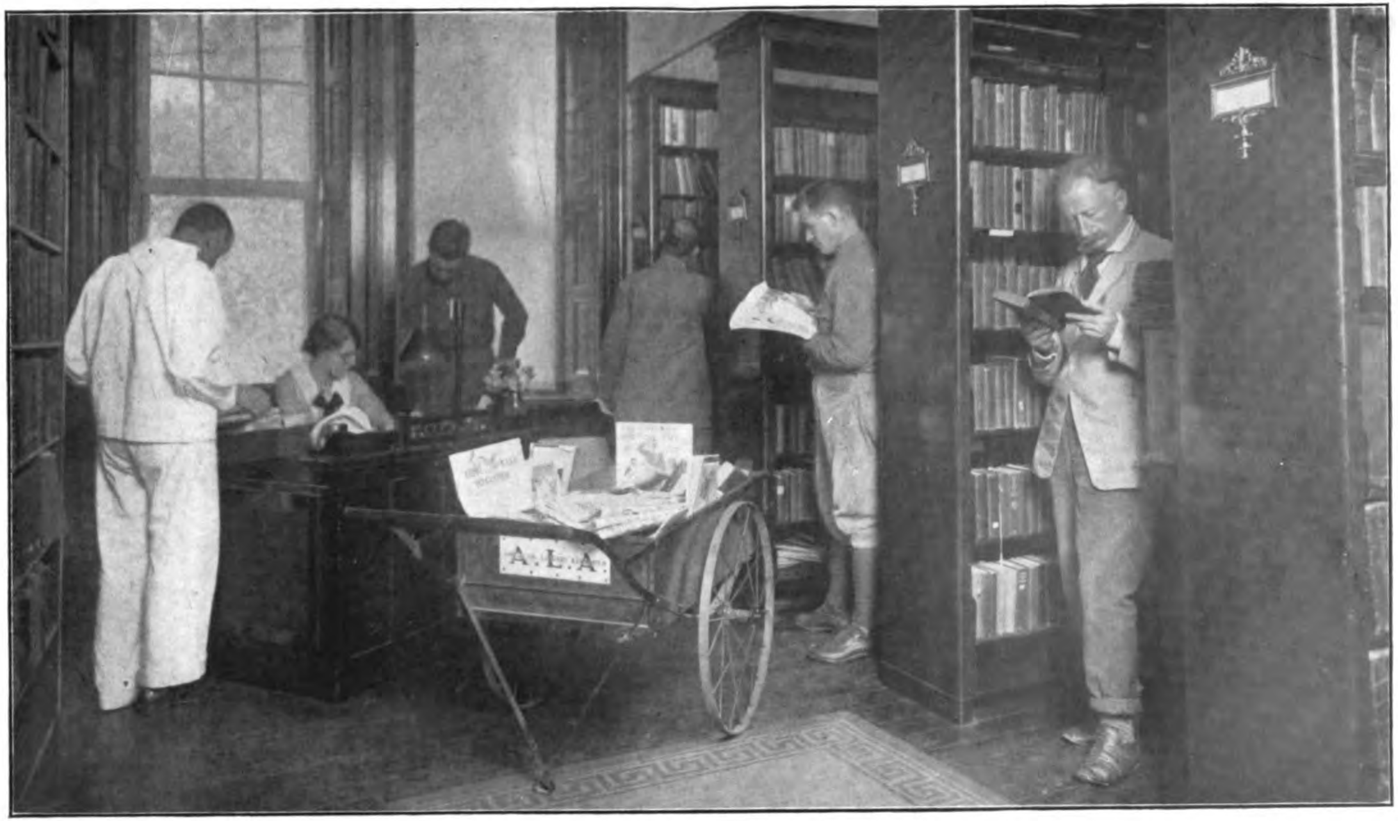
It was soon discovered that ward visiting equaled in value the service rendered in the reading room. A schedule was made so that all wards might be visited once or twice weekly. The disturbed patients were not neglected, for among them were found occasional patients who were glad to receive magazines or scrapbooks; the material left with them was of such a nature that it would be no great loss, if destroyed.

Attendants always accompanied me through the "disturbed" wards and were very kind in aiding me by introducing to me those patients who were able to read or look at pictures. Scrapbooks proved to be of inestimable value in all wards. Home papers were asked for continually, and were supplied to patients who did not care to have any other reading matter.

It was the belief of the medical officers that in the diversion provided the patients, both those who used the reading room and those served in the wards, the library performed a not unimportant therapeutic function. In addition to the reading itself, in the library workroom nearby work of various kinds was done by patients who time and again expressed a desire to have something to do. They sorted magazines, which came



Hospital librarian making rounds with her book truck



Librarian's desk and stack room, St. Elizabeths Hospital, Washington, D. C.

to the library in great numbers weekly, made scrapbooks, picked flowers for the reading room, and accomplished numerous other tasks, thus pleasantly occupying their leisure time and aiding the librarian. Occasionally one would be discovered who was able to use a typewriter. One patient enjoyed wheeling the book cart back and forth from the library to the wards and serving as a page. He formerly had delivered papers on the hospital grounds and was thus familiar with all the hospital wards and knew the patients in them. Needless to say he was of great value to the librarian. His condition constantly improved and it is possible that the diversion and the renewed sense of responsibility had something to do with this.

Besides being of recreative and therapeutic value, the library served still another purpose. By supplying vocational books on every trade and profession that were of interest, not only to the army and navy detachment men who soon expected their discharge, but also to patients who wished additional information concerning their former occupations, and by furnishing books of interest to foreigners who wanted to learn the English language, the library performed a special educational function. Greatly to my surprise, patients were as much, if not more, interested in the vocational books than the detachment men. One patient eagerly devoured books and government publications on bee-keeping; another asked for books on sheet-metal work; still another requested a book on veterinary pathology. It was remarkable to note that earnest reading was constantly done along such lines.

From such a limited experience it would not be safe to draw too many conclusions about the most suitable material for library work in hospitals for mental disease, but from my observations both in the neuropsychiatric wards of general hospitals and at St. Elizabeths, I should say that as far as fiction is concerned O. Henry, Zane Grey, Bower, Bindloss, Beach, London, Twain, and Oppenheim were as popular there as elsewhere. Calls for non-fiction were varied. A list of material selected at random from my notebook will show the variety and scope of the requests. Plutarch's *Lives,* Shakespeare's *Julius Caesar* and *Richard III,* Homer's *Iliad,* and other classics were called for. Biographies of Washington, Lincoln, Napoleon, Roosevelt, Longfellow, and Whittier were enjoyed. Histories were extensively read, one particular reader devouring volume after volume of Macauley's *History of England*. Books in the foreign languages had a wide circulation and included the following: Czecho-Slovak, Polish, Spanish, French, Italian, Bohemian, Roumanian, and Russian, for all nationalities must be served. From one ward came the following requests for reading material in one day:

NON-FICTION

Book on the fourth dimension
Book on British costumes
Biology
Tailoring trade
Spanish grammar
Gas engines
Blue-print making
Italian grammar
Photography
Salesmanship
History of the Republican Party
Greek mythology

FICTION

Tarsan of the Apes
Thelma

It is interesting to note the percentage of non-fiction.

The following note from one of the patients confined in the prison wards speaks for itself:

> "*Miss Librarian:*
>
> "I wish to thank you very much for the patience you show in selecting the books which are sent to this hall, and as we send for quite a lot, I am sure it is very trying to look up all of these; but as we inmates have the misfortune to be confined behind walls, reading is about the only diversion we can occupy our minds with. So we look forward to getting these books with great enjoyment. So whatever trouble you go to in selecting these books, you can feel that you are doing a very great favor to many unfortunates, and that it is sincerely appreciated,
>
> Sincerely yours,
>
> ________________"

If special training is needed to conduct an organization that gives mental food to the well, how much more important it is that a similar organization that gives mental food to the sick, especially the sick in mind, shall be in the hands of one who has been especially trained for the work.

PATIENTS WITH MENTAL DISEASE, MENTAL DEFECT, EPILEPSY, ALCOHOLISM AND DRUG ADDICTION IN INSTITUTIONS IN THE UNITED STATES, JANUARY 1, 1920

HORATIO M. POLLOCK, Ph.D.
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Statistician, The National Committee for Mental Hygiene

WITH the coöperation of institutions in the several states, the National Committee for Mental Hygiene presents its third census of patients with mental disease, mental defect, epilepsy, alcoholism and drug addiction. The former enumerations were made on January 1, 1917, and January 1, 1918. The purpose of this census is threefold: first, to ascertain the total number of such patients receiving treatment on January 1, 1920; second, to furnish a basis for comparison with the 1920 census of the general population of the country; and third, to show the changes that have taken place in institutional care since 1910.

Although most of the institutions caring for the classes enumerated generously coöperated by promptly filling out the schedules sent them by the committee, the most diligent effort failed to elicit the desired data from a few institutions. In these cases the patient population was estimated from data available in previous reports. The possible errors in these estimates are insignificant in relation to the magnitude of the totals in the several states.

Data for this study were obtained from Public Health Service hospitals in addition to the state, city and county, and private institutions included in previous studies. The institutions represented are classified as follows:

1. Number of institutions	625
a. Public	388
b. Private	237

2. Public institutions for mental diseases	
a. State hospitals	156
b. Federal hospitals	2
c. County and city institutions (not including those for temporary care)	125
d. Institutions for temporary care	21
3. State institutions for mental defectives	32
4. State institutions for mental defectives and epileptics	11
5. State institutions for epileptics	10
6. City institutions for mental defectives	1
7. Private institutions	
a. Having mentally diseased patients only	60
b. Having mental defectives only	27
c. Having epileptics only	6
d. Having mental defectives and epileptics only	19
e. Having inebriates (alcoholics and drug addicts) only	12
f. Having more than one of these classes (excluding "d" above)	113
8. Public Health Service hospitals	30

No schedules were sent to almshouses or penal or reformatory institutions.

This census differs from those taken in 1917 and 1918 in the care taken to exclude all patients on parole or otherwise absent from the institutions. The 1917 and 1918 censuses included all patients on the books of the hospitals whether temporarily absent or not. In view of the rapid development of the parole system in several states during the past five years, the paroles now constitute a disturbing factor in making statistical comparisons in different periods. In 1910, when the last federal census of the insane and feebleminded was taken, paroles were so few that they were considered a negligible factor.

Patients With Mental Disease

(See Table I, page 156.)

On January 1, 1920, there were 232,680 patients with mental disease actually in institutions in the United States. Of these, 200,109 were in state hospitals, 21,584 in county or city institutions, 1,040 in institutions for temporary care, 709 in Public Health Service hospitals, and 9,238 in private hospitals. In 1918 the total number of patients with mental disease reported on the books of the several institutions was 239,820. Of this number 15,863 were reported as on parole from the state hospitals on the day of enumeration. The number on parole from private institutions was not obtained, but it is believed to be very small. The number of patients actually in the institutions on January 1, 1918, was approximately 223,957, or 8,723 less than the number on January 1, 1920.

In all but 8 of the states the patients in public institutions are found exclusively in state hospitals. Wisconsin is the only state in which a majority of these patients is in county institutions. In 12 states there are institutions for the temporary care of mental cases, including psychopathic hospitals, psychopathic wards in general hospitals, and detention hospitals. In 32 states there are private institutions for mental patients, but in only 3 does the number thus cared for reach 1,000. In 15 states the number is less than 100. In Maryland the percentage of patients cared for in private institutions is 26.6. In all of the other states the percentage is much lower.

Sex of Patients with Mental Disease

Of the 232,680 patients with mental disease in institutions on January 1, 1920, 121,031 were males and 111,649, females. The percentages were 52.0 and 48.0 respectively. The number of males to each 100 females was 108.4. In 1918 the number was 110.6; in 1910, 110.8; in 1904, 109.6; in 1890, 107.4; and in 1880, 101.6.

With the marked decline in alcoholic psychoses and the gradual reduction of the syphilitic psychoses it is probable that the excess of males in the hospitals for mental diseases and among admissions to them will ultimately disappear.

The sex distribution of the mental patients in the several states varies more widely than that of the general population. In most of the Eastern and Southern states the women patients outnumber the men, while in the Western states the men patients are in the majority. The ratios in 1920 and in 1918 in some of the more populous states were:

	Number of male patients to each 100 female patients	
	1918	1920
California	142.3	133.5
Illinois	116.5	109.9
Massachusetts	98.1	94.4
Michigan	118.0	114.6
New York	90.3	90.5
Ohio	113.4	113.1
Pennsylvania	114.5	112.3
Wisconsin	125.5	124.1

MENTAL DEFECTIVES

(See Table II, page 158.)

The total number of mental defectives in institutions in the United States on January 1, 1920, was 40,519. Of these, 34,836 were in state institutions, 2,732 in other public institutions and 2,951 in private institutions. Mental defectives were reported in state institutions in all states except Delaware, Georgia and New Mexico, although on January 1, 1920, there were 14 states that had no separate institutions caring for such patients. The mental defectives reported in state institutions in Alabama, Arizona, Arkansas, Florida, Louisiana, Mississippi, Nevada, South Carolina, Tennessee, Utah and West Virginia were cared for in hospitals for mental disease. Of the 34,836 mental defectives in state institutions, 28,833, or 82.8 per cent, were in state institutions especially established for their care.

Compared with the census of mental defectives of January 1, 1918, there has been an increase of 2,047 in state institutions, a decrease of 756 in other public institutions and a decrease of 153 in private institutions. The increase in total patients amounts to 1,138. As only a small portion of the total number of mental defectives is cared for in institutions the census throws no light on the prevalence of mental defect in the general population.

Sex of Mental Defectives in Institutions

Of the 40,519 mentally defective persons under treatment on January 1, 1920, 20,123 were males and 20,396 were females. In the several states there is considerable variation in the proportion of the two sexes found in institutions, but the differences in the various sections of the country in this respect are not nearly so great as are found in the figures relating to patients with mental disease.

EPILEPTICS

(See Table III, page 159.)

Exclusive of the epileptics included among the patients with mental disease, there were on January 1, 1920, 14,937 epileptics under treatment in institutions of the United States. Of these, 13,223 were cared for in state institutions, 859 in other public institutions and 855 in private institutions. Compared with the census of January 1, 1918, there was an increase of 2,781 epileptics in state institutions, a decrease of 92 in other public institutions and an increase of 304 in private institutions. The total increase in all institutions was 2,993. The prevalence of epilepsy in the general population is not indicated by these figures as only a small proportion of the total number of epileptics is in institutions.

Colorado, Delaware, Georgia, Nebraska, New Mexico and Washington report no epileptics in state institutions other than those included among the patients with mental disease. In only 12 states are epileptics cared for in city or county institutions. Nearly one-half of the epileptics in private institutions are reported from Pennsylvania.

Sex of Epileptics in Institutions

Of the 14,937 epileptics in institutions on January 1, 1920, 7,939 were males and 6,998, females. In several states the two sexes are found in nearly equal numbers, but in Indiana, Kansas, Virginia, West Virginia and Wisconsin the male patients greatly exceed the female.

ALCOHOLICS

(See Table IV, page 160.)

The alcoholics in institutions in the several states on January 1, 1920, other than those included among the patients with mental disease, numbered 1,163. Of these, 587 were cared for in state institutions, 331 in other public institutions and 245 in private institutions.

In the census of 1918 the alcoholics and drug addicts were included in one group under the term "inebriates." In the present census the two classes were separated. In view of the oft-expressed opinion that the restrictions of the sale of alcoholic beverages would greatly increase the use of drugs, it is noteworthy that the total number of alcoholic and drug inebriates in institutions in the United States decreased from 3,565 on January 1, 1918, to 1,971 on January 1, 1920. On January 1, 1917, the total inebriates in institutions in this country numbered 4,891, or two and one-half times the number shown by the 1920 census.

While there are many alcoholics and drug addicts outside of institutions, the marked reduction of the number in institutions indicates that the number outside is also decreasing. This conclusion is further supported by the fact that the number of alcoholic and drug cases among first admissions to the New York State hospitals for mental diseases has markedly declined in recent years.

Of the 1,163 alcoholics in institutions on January 1, 1920, 217, or 18.7 per cent, were in Illinois; 137, or 11.8 per cent, in Iowa; 127, or 10.9 per cent, in Pennsylvania; 80, or 6.9 per cent, in Wisconsin; and 71, or 6.1 per cent, in New Jersey. The remaining 531, or 45.7 per cent, were scattered through 33 states. No alcoholics were reported from 10 states.

Nine hundred ninety-four of the alcoholics in institutions were males and 169 females, or 6 males to each female.

Drug Addicts

(See Table V, page 161.)

The drug addicts in institutions in the United States on January 1, 1920, numbered 808. Of these, 314 were in state institutions, 78 in other public institutions and 416 in private institutions. These figures throw little light on the prevalence of drug addiction as most drug addicts are not receiving institutional care. As no other separate census of drug addicts in institutions has been taken in recent years no basis of comparison is available.

Of the 808 drug addicts in institutions 544 were males and 264 females, or 2 males to each female. New York is the only state in which the number of drug addicts reported reached 100.

INCREASE OF PATIENTS WITH MENTAL DISEASE IN INSTITUTIONS COMPARED WITH INCREASE OF THE GENERAL POPULATION

(See Tables VI, VII and VIII, pages 162-66.)

The institutional care of the insane has increased enormously since 1880, when the first separate federal census of the insane in institutions was taken. The absolute numbers of patients under treatment as well as the rates of patients to population have increased at each succeeding census.

Patients with Mental Disease in Institutions, 1880–1920

Year	Number	Per 100,000 of general population
1880	40,942	81.6
1890	74,028	118.2
1904	150,151	183.6
1910	187,791	204.2
1918	223,957*	217.5
1920	232,680*	220.1

* Excluding paroles.

These figures indicate that a constantly increasing proportion of the insane is being cared for in institutions. That the rate of incidence of mental disease based on the general population has increased much less rapidly than that of institutional care is shown by the record of first admissions to the New York State hospitals during the past decade.*

Table VI shows the increase by sexes in the number of patients with mental disease in institutions in the several states from January 1, 1910, to January 1, 1920. The percentages of increase for the whole country were: males 22.6, females 25.3, total 23.9. The general population during the same period increased 14.9 per cent.

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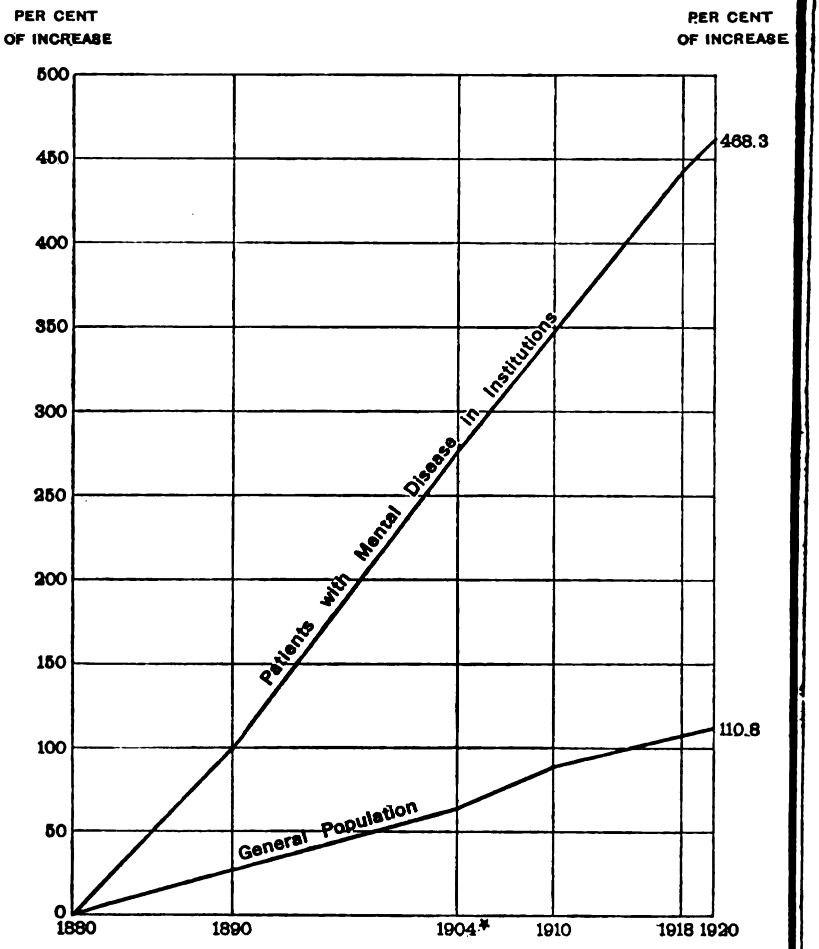
* *Thirty-first Annual Report of the State Hospital Commission.* Albany: New York State Hospital Commission, 1920. p. 275.

INCREASE OF PATIENTS WITH MENTAL DISEASE IN INSTITUTIONS COMPARED WITH INCREASE OF GENERAL POPULATION OF THE UNITED STATES. 1880-1920



*No special census of patients was taken in 1900

States with High Rates of Increase of Mental Patients under Treatment Compared with Increase of Population

State	Per cent of increase, 1910-1920 Patients	General population
California	53.1	44.1
Colorado	40.1	17.6
Florida	44.4	28.7
Idaho	40.5	32.6
Montana	58.1	46.0
New Mexico	62.6	10.1
North Dakota	97.9	11.9
Oklahoma	79.3	22.4
Oregon	55.7	16.4
Utah	56.1	20.4
Washington	72.3	18.8

In Vermont there was an increase of 10.6 per cent in mental patients and a decrease of 1.0 per cent in general population.

States with Low Rates of Increase of Mental Patients under Treatment Compared with Increase of Population

State	Per cent of increase, 1910-1920 Patients	General population
Alabama	9.8	9.8
Connecticut	22.6	23.9
Delaware	11.3	10.2
Illinois	15.9	15.0
Iowa	10.9	8.1
Kansas	4.9	4.6
Louisiana	8.9	8.6
Michigan	15.4	30.5
New Jersey	22.4	24.4
Ohio	15.3	20.8
West Virginia	5.0	19.9

The only states in which there was a decrease both in mental patients in institutions and in general population were Mississippi and Nevada.

The most remarkable result shown by the table is the disparity in the percentage increase in the number of patients of the two sexes in certain states. Some of the most striking differences in percentages of increase are:

State	Percentage increase of patients, 1910-1920 Males	Females
Arizona	26.4	86.1
California	41.5	71.9
Colorado	34.8	47.3
Idaho	36.3	48.5
Kansas	0.3	11.2
Maine	18.5	46.2
Maryland	17.6	28.9
Missouri	7.3	18.4
Montana	38.0	122.3
Oklahoma	64.1	100.9
Oregon	48.6	71.9
South Carolina	29.5	17.3
South Dakota	29.3	48.9
Texas	29.2	46.9
Utah	70.2	42.1
Vermont	4.5	17.5
Washington	59.8	97.1
Wyoming	60.0	40.4

The causes of these remarkable inequalities in the increase of patients in the two sexes are not known. In Massachusetts, New York and Ohio the differences in the percentages of increase of patients in the two sexes are comparatively slight.

Table VII gives a comparison of the number and rate per 100,000 of patients with mental disease in the United States by divisions and states in 1910 and 1920. The rate of mental patients per 100,000 of general population increased from 204.2 in 1910 to 220.2 in 1920. The rates in the several divisions are shown in the following table:

Rates of Patients with Mental Disease in Institutions in the Several Divisions of the United States, 1910–1920

Division	Rank	Number per 100,000 1910	1920
New England	1	298.8	328.1
Middle Atlantic	2	271.2	292.3

Division	Rank	Number per 100,000 1910	 1920
East North Central	4	226.0	225.1
West North Central	5	194.9	215.1
South Atlantic	6	163.6	171.0
East South Central	8	116.0	121.5
West South Central	9	95.8	111.1
Mountain	7	135.7	154.5
Pacific	3	243.4	288.2

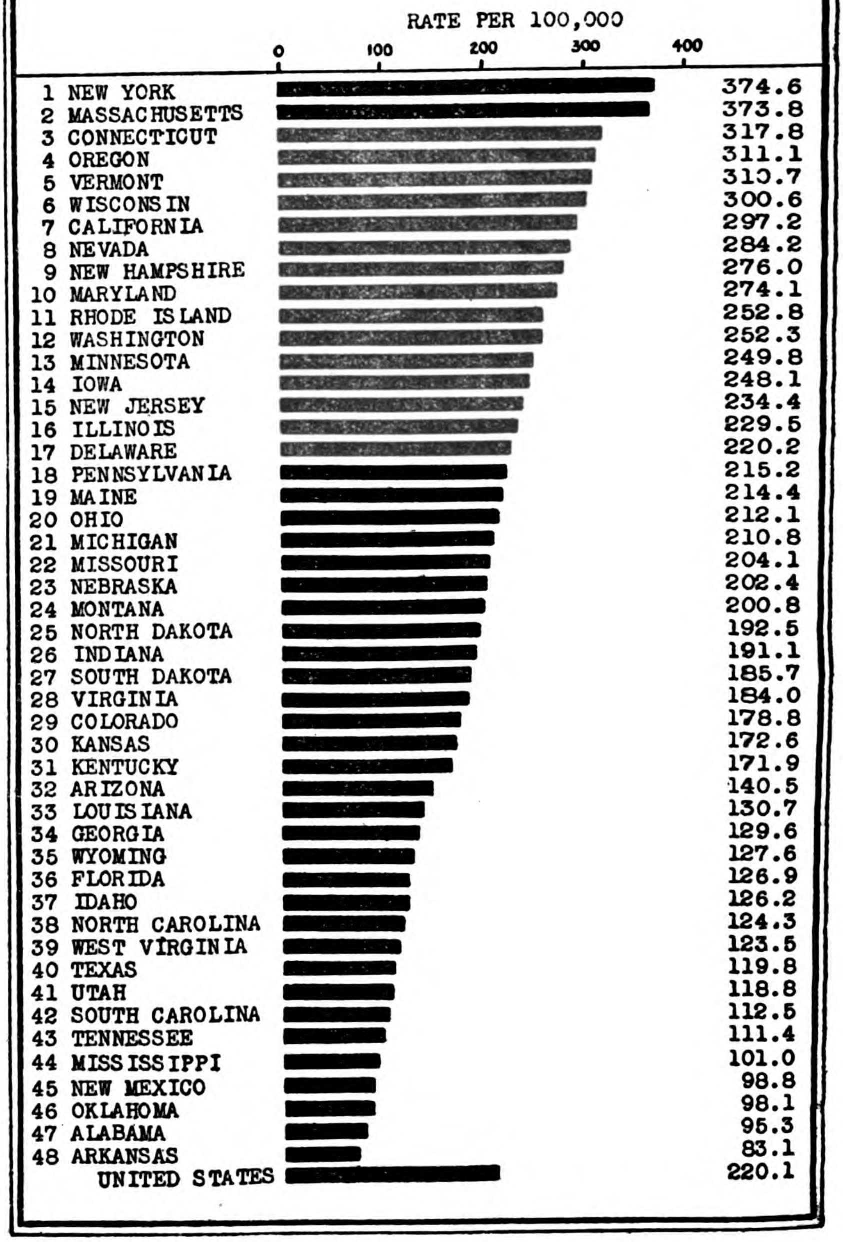
The only division in which a decrease in the number of patients per 100,000 of population is shown is the East North Central. The decrease in this division may be accounted for by the rapid increase in population of Ohio and Michigan. The workers who have migrated to these states in the past three years are for the most part young and virile and have not resided there long enough to affect the population of the institutions. With the development of institutions for the insane in the Southern and Western states the rates of patients under treatment in the several divisions will become more nearly equal. A tendency to equalization is noticeable in the figures of 1910 and 1920. The accompanying chart gives a comparison of the rates of patients under treatment in the several states. New York heads the list with Massachusetts a close second.

Table VIII gives a general view of the increase of patients with mental disease in institutions in the several states since 1890. It is noteworthy that the total number of patients has more than doubled during these three decades, while in several of the newer states the number of patients now cared for is more than five times the number cared for in 1890.

PATIENTS ABSENT FROM INSTITUTIONS BUT STILL ON BOOKS

(See Table IX, page 167.)

The term "absent from institution, but still on books" includes patients on parole and escape or otherwise temporarily away from the institution. Owing to the lack of uniformity in the parole laws of the several states, the relation of the patients on parole to the institution is not the same in all cases. In Michigan, patients are considered on the books of the hospital for one year from the time of their discharge,



PATIENTS WITH MENTAL DISEASE IN INSTITUTIONS IN THE UNITED STATES, WITH RATES PER 100,000 OF GENERAL POPULATION, JANUARY 1, 1920 while in most states patients are temporarily released on parole pending their final discharge from the books of the institution. The period of parole varies from 30 days to 2 years, the most usual period being 6 months. In some states only private patients are paroled. Some states have a well organized system of after-care and supervision under the direction of social workers while other states exercise no supervision over patients on parole. The total number of patients reported as absent from state hospitals, but still on books on January 1, 1920, was 18,268, an increase of 2,405 since January 1, 1918. Owing to the different conditions under which patients are paroled, a comparison of the numbers and percentages on parole in the different states has little significance.

Increase of Mental Defectives in Institutions, 1910–1920

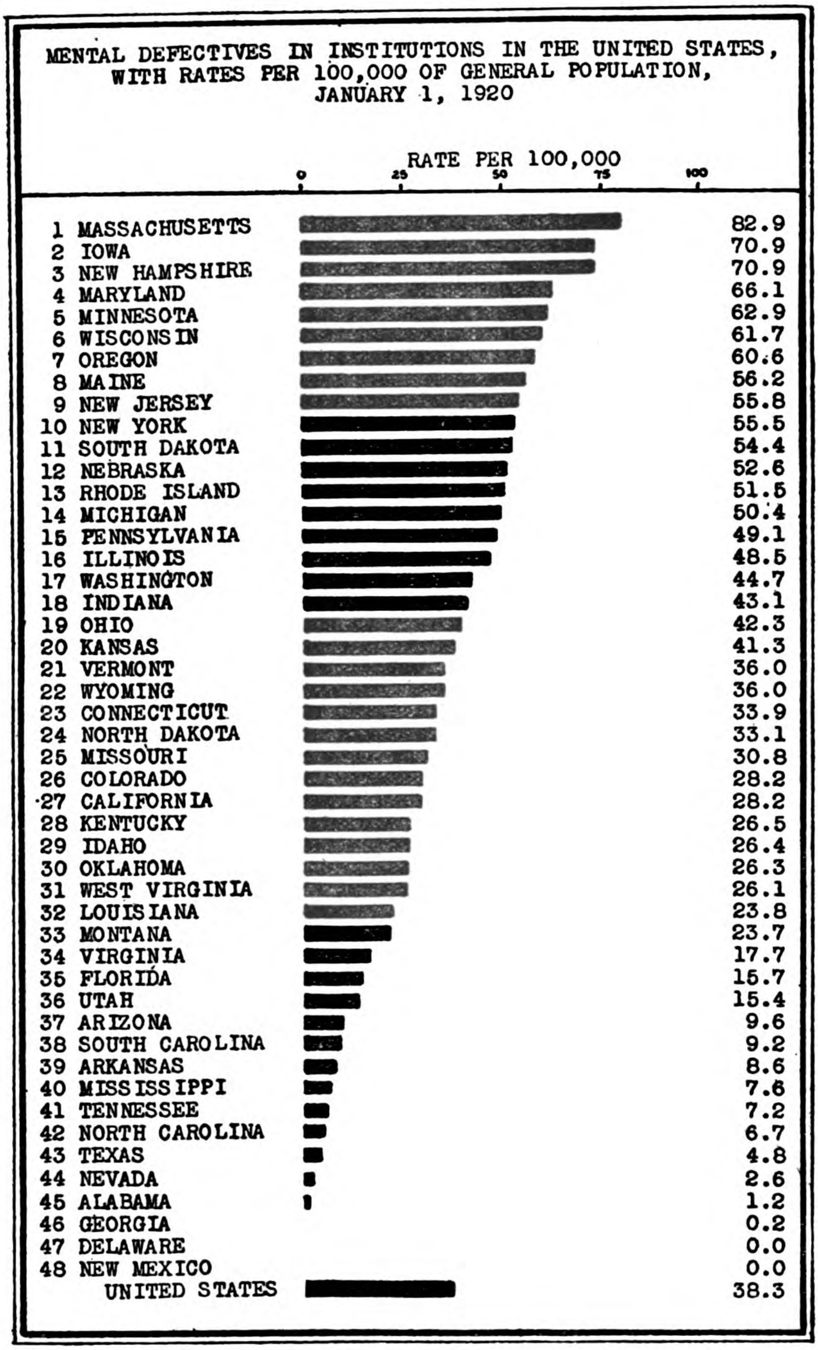
(See Table X, page 168.)

Table X shows the rapid development in the institutional care of mental defectives in many states of the Union. In 1910, when the federal census of mental defectives in institutions was taken, 17 of the 48 states reported no mental defectives in institutions. On January 1, 1920, all of the states except two reported mental defectives under institutional care. During the 10 years covered by the table the number of mentally defective patients increased from 20,731 to 40,519 and the rate of patients per 100,000 of general population from 22.5 to 38.3. While the number of mental defectives outside of institutions, but in need of institutional care is not definitely known, intensive county surveys indicate that present provision for them is very inadequate even in states like Massachusetts and New York where present rates of mentally defective patients under treatment are much higher than those for the country as a whole. The accompanying chart gives a comparison of the rates of mental defectives in institutions of the several states.

Patients in United States Public Health Service Hospitals, January 1, 1920

(See Table XI, page 169.)

At the time this census was taken, the United States Public Health Service had established or developed from existing



MENTAL DEFECTIVES IN INSTITUTIONS IN THE UNITED STATES, WITH RATES PER 100,000 OF GENERAL POPULATION, JANUARY 1, 1920

Marine Hospitals 43 hospitals in which ex-service men and women who were beneficiaries of the Bureau of War Risk Insurance were cared for. At the present time there are 54 such hospitals. Mental and nervous cases are admitted to nearly all these hospitals in emergencies and for temporary care, but an effort has been made to provide continued care only in special neuropsychiatric hospitals. In some of the larger general Public Health Service hospitals there are psychiatric wards. The special neuropsychiatric hospitals now receiving patients with psychoses are Public Health Service Hospital No. 44, at West Roxbury, Massachusetts; Public Health Service Hospital No. 49, at Philadelphia; and Public Health Service Hospital No. 57, at Knoxville, Iowa. Public Health Service Hospital No. 37, at Waukesha, Wisconsin, and Public Health Service Hospital No. 42, at Perryville, Maryland, are for psychoneuroses, and Public Health Service Hospital No. 34, at East Norfolk, Massachusetts, is for the treatment of epilepsy. As the legal residence of many of the patients in these institutions is in states other than those in which they are cared for, no attempt has been made to distribute these patients by states in the foregoing tables. The total patients in these institutions belonging to the several classes enumerated have been included in the tables for the country as a whole. As many soldiers and sailors with mental disease are being cared for in state and private institutions, the numbers given in Table XI give no indication of the extent to which former members of the army and navy are now being cared for in institutions.

NEW INSTITUTIONS

The most noteworthy feature in the extension of institutional care since the publication of the 1918 census is the establishment of new state institutions for mental defectives, particularly in the South. Such institutions were authorized in 1918 by the legislatures in Louisiana and South Carolina; in 1919, in Alabama, Florida, Georgia, and Tennessee; and in 1920, in Mississippi. Of these institutions the ones in Mississippi and South Carolina have recently been opened, and it is expected that those in Florida and Georgia will be ready to receive mental defectives in the near future. A second institution for mental defectives in both Indiana and Ohio was authorized in 1919. The one in Indiana—The Farm Colony for the Feebleminded, located at Butlerville—is not yet ready to receive commitments, but is at present caring for a few male patients received by transfer from the Indiana School for Feebleminded Youth.

The Pacific Colony, California's second institution for mental defectives, authorized in 1917, will probably be opened in January, 1921. The first patients to be received will be 40 boys of the high-grade moron type who will assist in the development of the colony site. The Delaware state institution for mental defectives, which was authorized in 1917, is expected to open soon. The Idaho State Sanitarium, established by the 1913 legislature for the care of both mental defectives and epileptics, was opened in 1918. The 1919 legislature of Illinois changed the status of the Dixon State Colony, which was created by the legislature of 1913 and opened in 1918 as a separate institution for epileptics, so that this institution now receives both mental defectives and epileptics. The Southern Wisconsin Home for Feebleminded and Epileptics received its first patients on February 14, 1919. The Pennsylvania Village at Laurelton, authorized in 1913 as an institution for feebleminded women, received its first charges on January 2, 1920. Massachusetts' third institution for mental defectives, which was authorized by the 1915 legislature and located at Belchertown, is not yet completed, but was opened in 1919 to receive a few male patients. This institution is under the supervision of the Wrentham State School during construction.

A state psychopathic hospital was authorized in 1919 in Iowa to be located at the State University. The 1919 legislature of Colorado also enacted a law to establish a state psychopathic hospital, but without any appropriation for its construction or maintenance. The matter of appropriation was referred to the voters of Colorado at the 1920 election and the sum of $350,000 was thus authorized for this hospital. By an act of the 1920 legislature of Massachusetts, the Psychopathic Department of the Boston State Hospital was changed to a separate state hospital, to be known as The Boston Psychopathic Hospital.

Two state hospitals for mental diseases have been opened since 1918—The Western State Hospital for Insane, at Torrance, Pennsylvania, which was established by the 1915 legislature of that state, and the East Texas Hospital for the Insane, at Rusk, a hospital for colored patients, authorized in 1917.

The Marion Branch of the National Home for Disabled Volunteer Soldiers has recently been converted into the Marion National Sanatorium for the treatment of mental disorders.

A significant change in institutions is the discontinuance of hospitals for inebriates. In 1917, the Willmar State Asylum, Minnesota, opened in 1912 as a state hospital for inebriates, became a hospital for mental diseases. The Connecticut State Hospital for Inebriates, a department of the Norwich State Hospital, is now used as an integral part of the hospital and is receiving patients with mental diseases. Although this institution has not been closed by official action, it has ceased to function as a hospital for inebriates since February 1, 1920. The State Hospital for Inebriates, at Knoxville, Iowa, was officially closed, December 1, 1919. It is now United States Public Health Service Hospital No. 57, for the treatment of mental defectives. The Norfolk State Hospital, which was opened in 1914 to care for inebriates, is now United States Public Health Service Hospital No. 34, for the treatment of epilepsy. With the discontinuance of these four hospitals, there are at the present time no state hospitals for inebriates. The New York City Industrial Colony discontinued receiving inebriates in October, 1918, and was closed in December of that year.

Table I—Patients with mental disease in institutions in the several states of the Union, January 1, 1920*

STATE	TOTAL			PUBLIC									PRIVATE		
				STATE INSTITUTIONS			COUNTY OR CITY INSTITUTIONS			INSTITUTIONS FOR TEMPORARY CARE					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	121,031	111,649	232,680	105,134	94,975	200,109	10,855	10,729	21,584	561	481	1,040	3,773	5,465	9,238
Alabama	1,066	1,172	2,238	1,065	1,171	2,236	......	......	......	......	......	......	1	1	2
Arizona	335	134	469	335	134	469	......	......	......	......	......	......	......	......	......
Arkansas	737	719	1,456	737	719	1,456	......	......	......	......	......	......	......	......	......
California	5,823	4,361	10,184	5,688	4,240	9,928	......	......	......	52	14	66	83	107	190
Colorado	926	754	1,680	872	702	1,574	......	......	......	8	3	11	46	49	95
Connecticut	2,134	2,253	4,387	1,965	1,946	3,911	......	......	......	......	......	......	169	307	476
Delaware	256	235	491	256	235	491	......	......	......	......	......	......	......	......	......
District of Columbia	2,494	848	3,342	2,436	845	3,281	......	......	......	58	3	61	......	......	......
Florida	638	588	1,226	638	588	1,226	......	......	......	......	......	......	......	......	......
Georgia	1,831	1,923	3,754	1,806	1,881	3,687	......	......	......	......	......	......	25	42	67
Idaho	349	196	545	349	196	545	......	......	......	......	......	......	......	......	......
Illinois	7,794	7,090	14,884	7,675	6,910	14,585	......	......	......	47	40	87	72	140	212
Indiana	2,866	2,733	5,599	2,747	2,630	5,377	110	100	210	......	......	......	9	3	12
Iowa	3,219	2,745	5,964	2,421	1,878	4,299	623	588	1,211	......	......	......	175	279	454
Kansas	1,699	1,355	3,054	1,679	1,331	3,010	......	......	......	......	......	......	20	24	44
Kentucky	2,249	1,905	4,154	2,230	1,887	4,117	......	......	......	......	......	......	19	18	37
Louisiana	1,131	1,220	2,351	1,035	1,051	2,086	......	......	......	39	36	75	57	133	190
Maine	821	826	1,647	813	812	1,625	......	......	......	......	......	......	8	14	22
Maryland	1,845	2,128	3,973	1,326	1,328	2,654	......	......	......	117	145	262	402	655	1,057
Massachusetts	6,993	7,406	14,399	6,840	7,122	13,962	......	......	......	41	42	83	112	242	354
Michigan	4,129	3,604	7,733	3,599	2,875	6,474	350	429	779	21	36	57	159	264	423
Minnesota	3,396	2,568	5,964	3,367	2,531	5,898	......	......	......	......	......	......	29	37	66
Mississippi	801	1,008	1,809	801	1,008	1,809	......	......	......	......	......	......	......	......	......

Missouri	**3,468**	**3,478**	**6,946**	**2,339**	**2,020**	**4,359**	**873**	**1,065**	**1,938**				**256**	**393**	**649**
Montana	**733**	**369**	**1,102**	**733**	**369**	**1,102**									
Nebraska	1,478	1,146	2,624	1,446	1,110	2,556							32	36	68
Nevada	159	61	220	159	61	220									
New Hampshire	605	618	1,223	605	618	1,223									
New Jersey	3,507	3,891	7,398	2,151	2,110	4,261	1,312	1,729	3,041	16	10	26	28	42	70
New Mexico	206	150	356	206	150	356									
New York	18,480	20,423	38,903	18,004	19,493	37,497				84	89	173	392	841	1,233
North Carolina	1,343	1,837	3,180	1,320	1,795	3,115							23	42	65
North Dakota	801	442	1,243	801	442	1,243									
Ohio	6,483	5,734	12,217	6,370	5,568	11,938				23	14	37	90	152	242
Oklahoma	1,068	922	1,990	1,004	840	1,844							64	82	146
Oregon	1,617	820	2,437	1,422	783	2,205							195	37	232
Pennsylvania	9,924	8,840	18,764	5,100	4,148	9,248	3,960	3,700	7,660	54	48	102	810	944	1,754
Rhode Island	794	734	1,528	729	670	1,399							65	64	129
South Carolina	917	977	1,894	915	965	1,880							2	12	14
South Dakota	692	490	1,182	692	490	1,182									
Tennessee	1,197	1,408	2,605	967	1,136	2,103	211	244	455				19	28	47
Texas	2,697	2,889	5,586	2,619	2,789	5,408							78	100	178
Utah	291	243	534	291	243	534									
Vermont	552	543	1,095	338	354	692							214	189	403
Virginia	2,133	2,117	4,250	2,125	2,102	4,227							8	15	23
Washington	2,118	1,305	3,423	2,113	1,295	3,408							5	10	15
West Virginia	977	831	1,808	977	831	1,808									
Wisconsin	4,382	3,530	7,912	860	493	1,353	3,416	2,874	6,290				106	163	269
Wyoming	168	80	248	168	80	248									
U. S. Public Health Service hospitals	709		709												

*Patients absent from institution but still on books are not included.

Table II—Mental defectives in institutions in the several states of the Union, January 1, 1920

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	20,123	20,396	40,519	17,060	17,776	34,836	1,453	1,279	2,732	1,610	1,341	**2,951**
Alabama	11	18	29	11	18	29	....	....	....	....	....	....
Arizona	18	14	32	18	14	32	....	....	....	....	....	....
Arkansas	75	75	150	75	75	150	....	....	....	....	....	....
California	474	491	965	463	471	934	....	....	....	11	20	**31**
Colorado	163	102	265	148	94	242	....	....	....	15	8	**23**
Connecticut	247	221	468	237	212	449	....	....	....	10	9	**19**
Delaware	....	....	....	....	....	....	....	....	....	....	....	....
Dist. of Columbia	5	1	6	....	....	....	5	1	6	....	....	....
Florida	79	73	152	79	73	152	....	....	....	....	....	....
Georgia	6	....	6	....	....	....	....	....	....	6	....	**6**
Idaho	63	51	114	63	51	114	....	....	....	....	....	....
Illinois	1,677	1,470	3,147	1,640	1,427	3,067	....	....	....	37	43	**80**
Indiana	582	682	1,264	561	668	1,229	21	14	35	....	....	....
Iowa	860	844	1,704	710	705	1,415	124	105	229	26	34	**60**
Kansas	359	372	731	358	372	730	....	....	....	1	....	**1**
Kentucky	337	304	641	280	276	556	....	....	....	57	28	**85**
Louisiana	234	194	428	225	141	366	2	3	5	7	50	**57**
Maine	229	203	432	229	203	432	....	....	....	....	....	....
Maryland	463	495	958	443	460	903	18	9	27	2	26	**28**
Massachusetts	1,678	1,514	3,192	1,627	1.459	3,086	....	....	....	51	55	**106**
Michigan	990	859	1,849	933	816	1,749	5	3	8	52	40	**92**
Minnesota	764	738	1,502	744	719	1,463	....	....	....	20	19	**39**
Mississippi	79	57	136	79	57	136	....	....	....	....	....	....
Missouri	525	522	1,047	371	352	723	109	102	211	45	68	**113**
Montana	86	44	130	86	44	130	....	....	....	....	....	....
Nebraska	359	323	682	359	320	679	....	....	....	....	3	**3**
Nevada	2	....	2	2	....	2	....	....	....	....	....	....
New Hampshire	150	164	314	150	164	314	....	....	....	....	....	....
New Jersey	709	1,053	1,762	183	779	962	118	102	220	408	172	**580**
New Mexico	....	....	....	....	....	....	....	....	....	....	....	....
New York	2,660	3,102	5.762	1,786	2,279	4,065	699	647	1,346	175	176	**351**
North Carolina	74	97	171	74	96	170	....	....	....	....	1	**1**
North Dakota	118	96	214	118	96	214	....	....	....	....	....	....
Ohio	1,211	1,224	2,435	1,206	1,222	2,428	1	1	2	4	1	**5**
Oklahoma	297	237	534	296	236	532	....	....	....	1	1	**2**
Oregon	216	259	475	209	256	465	....	....	....	7	3	**10**
Pennsylvania	2,147	2,134	4,281	1,531	1,627	3,158	178	129	307	438	378	**816**
Rhode Island	148	163	311	148	163	311	....	....	....	....	....	....
South Carolina	85	70	155	85	70	155	....	....	....	....	....	....
South Dakota	194	152	346	194	152	346	....	....	....	....	....	....
Tennessee	83	86	169	32	26	58	39	50	89	12	10	**22**
Texas	70	154	224	48	140	188	....	....	....	22	14	**36**
Utah	29	40	69	29	40	69	....	....	....	....	....	....
Vermont	44	83	127	31	73	104	....	....	....	13	10	**23**
Virginia	144	264	408	102	216	318	....	....	....	42	48	**90**
Washington	331	275	606	330	275	605	....	....	....	1	....	**1**
West Virginia	197	185	382	197	185	382	....	....	....	....	....	....
Wisconsin	760	864	1,624	527	627	1,154	86	113	199	147	124	**271**
Wyoming	43	27	70	43	27	70	....	....	....	....	....	....
U.S. Public Health Service hospitals	48	....	48	....	....	....	48	....	48	....	....	....

Table III—Epileptics in institutions in the several states of the Union, January 1, 1920

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	7,939	6,998	14,937	7,040	6,183	13,223	500	359	859	399	456	855
Alabama	3	6	9	3	6	9	...	...	...	...	...	...
Arizona	12	...	12	12	...	12	...	...	...	...	...	...
Arkansas	100	100	200	100	100	200	...	...	...	...	...	...
California	247	200	447	234	194	428	10	...	10	3	6	9
Colorado	5	...	5	...	...	...	...	...	...	5	...	5
Connecticut	55	61	116	48	52	100	...	...	...	7	9	16
Delaware	...	...	...	...	...	...	...	...	...	...	...	...
Dist. of Columbia	3	...	3	...	...	...	3	...	3	...	...	...
Florida	63	57	120	63	57	120	...	...	...	...	...	...
Georgia	1	4	5	...	...	...	...	...	...	1	4	5
Idaho	15	18	33	15	18	33	...	...	...	...	...	...
Illinois	382	405	787	375	395	770	1	...	1	6	10	16
Indiana	442	155	597	442	146	588	...	9	9	...	...	...
Iowa	266	237	503	242	214	456	24	23	47	...	...	...
Kansas	306	235	541	306	235	541	...	...	...	...	...	...
Kentucky	87	77	164	80	72	152	...	...	...	7	5	12
Louisiana	69	54	123	63	42	105	1	2	3	5	10	15
Maine	34	24	58	34	24	58	...	...	...	...	...	...
Maryland	75	74	149	70	48	118	...	...	...	5	26	31
Massachusetts	615	612	1,227	566	580	1,146	...	...	...	49	32	81
Michigan	426	416	842	423	416	839	...	...	...	3	...	3
Minnesota	149	160	309	147	159	306	...	...	...	2	1	3
Mississippi	90	88	178	90	88	178	...	...	...	...	...	...
Missouri	356	388	744	243	248	491	86	86	172	27	54	81
Montana	50	18	68	50	18	68	...	...	...	...	...	...
Nebraska	1	...	1	...	...	...	...	...	...	1	...	1
Nevada	1	2	3	1	2	3	...	...	...	...	...	...
New Hampshire	27	43	70	27	43	70	...	...	...	...	...	...
New Jersey	404	413	817	373	393	766	17	13	30	14	7	21
New Mexico	...	...	...	...	...	...	...	...	...	...	...	...
New York	842	841	1,683	712	703	1,415	102	118	220	28	20	48
North Carolina	96	86	182	93	83	176	...	...	...	3	3	6
North Dakota	35	34	69	35	34	69	...	...	...	...	...	...
Ohio	866	814	1,680	863	813	1,676	3	1	4	...	...	...
Oklahoma	193	172	365	188	171	359	...	...	...	5	1	6
Oregon	14	4	18	12	4	16	...	...	...	2	...	2
Pennsylvania	461	420	881	233	166	399	54	35	89	174	219	393
Rhode Island	19	17	36	18	17	35	...	...	...	1	...	1
South Carolina	80	65	145	80	65	145	...	...	...	...	...	...
South Dakota	2	3	5	2	3	5	...	...	...	...	...	...
Tennessee	66	39	105	43	23	66	23	16	39	...	...	...
Texas	294	259	553	292	257	549	...	...	...	2	2	4
Utah	12	16	28	12	16	28	...	...	...	...	...	...
Vermont	10	14	24	4	11	15	...	...	...	6	3	9
Virginia	266	168	434	260	157	417	...	...	...	6	11	17
Washington	...	...	...	...	...	...	...	...	...	...	...	...
West Virginia	165	94	259	165	94	259	...	...	...	...	...	...
Wisconsin	125	97	222	13	8	21	75	56	131	37	33	70
Wyoming	8	8	16	8	8	16	...	...	...	...	...	...
U. S. Public Health Service hospitals	101	...	101	...	...	...	101	...	101	...	...	...

Table IV—Alcoholics in institutions in the several states of the Union, January 1, 1920

(States reporting no alcoholics are omitted)

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	994	169	1,163	507	80	587	284	47	331	203	42	245
Alabama	1	....	1	1	....	1	....	....	....	....	....	....
Arizona	3	....	3	3	....	3	....	....	....	....	....	....
Arkansas	3	....	3	3	....	3	....	....	....	....	....	....
California	30	11	41	27	10	37	....	1	1	3	....	3
Colorado	11	....	11	11	....	11	....	....	....	....	....	....
Connecticut	8	1	9	....	....	....	....	....	....	8	1	9
Dist. of Columbia	2	....	2	....	....	....	2	....	2	....	....	....
Georgia	4	....	4	....	....	....	....	....	....	4	....	4
Idaho	9	....	9	9	....	9	....	....	....	....	....	....
Illinois	194	23	217	190	21	211	....	....	....	4	2	6
Indiana	1	....	1	1	....	1	....	....	....	....	....	....
Iowa	113	24	137	30	3	33	80	21	101	3	....	3
Kansas	1	....	1	....	....	....	....	....	....	1	....	1
Kentucky	1	....	1	....	....	....	....	....	....	1	....	1
Louisiana	26	6	32	11	5	16	2	....	2	13	1	14
Maine	12	1	13	12	1	13	....	....	....	....	....	....
Maryland	53	8	61	44	8	52	2	....	2	7	....	7
Massachusetts	4	12	16	....	....	....	....	....	....	4	12	16
Michigan	13	2	15	7	2	9	....	....	....	6	....	6
Minnesota	42	....	42	40	....	40	....	....	....	2	....	2
Mississippi	7	....	7	7	....	7	....	....	....	....	....	....
Missouri	23	10	33	3	2	5	3	8	11	17	....	17
Montana	22	9	31	22	9	31	....	....	....	....	....	....
Nebraska	1	....	1	1	....	1	....	....	....	....	....	....
Nevada	18	9	27	18	9	27	....	....	....	....	....	....
New Hampshire	1	....	1	1	....	1	....	....	....	....	....	....
New Jersey	61	10	71	36	8	44	25	2	27	....	....	....
New York	48	9	57	....	....	....	40	7	47	8	2	10
Ohio	9	1	10	....	....	....	6	1	7	3	....	3
Oklahoma	17	....	17	13	....	13	....	....	....	4	....	4
Pennsylvania	103	24	127	....	....	....	40	3	43	63	21	84
South Carolina	1	....	1	....	....	....	....	....	....	1	....	1
South Dakota	1	....	1	1	....	1	....	....	....	....	....	....
Tennessee	18	....	18	3	....	3	10	....	10	5	....	5
Texas	8	2	10	....	....	....	....	....	....	8	2	10
Vermont	29	1	30	1	....	1	....	....	....	28	1	29
Virginia	11	1	12	3	1	4	....	....	....	8	....	8
West Virginia	3	1	4	3	1	4	....	....	....	....	....	....
Wisconsin	76	4	80	6	....	6	68	4	72	2	....	2
U. S. Public Health Service hospitals	6	....	6	....	....	....	6	....	6	....	....	....

Table V—Drug addicts in institutions in the several states of the Union, January 1, 1920

(States reporting no drug addicts are omitted)

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States......	544	264	808	207	107	314	44	34	78	293	123	416
Alabama...........	5	1	6	3	1	4	.....	.....	.....	2	.....	2
Arizona............	3	.....	3	3	.....	3	.....	.....	.....	.....	.....	.....
Arkansas..........	6	2	8	6	2	8	.....	.....	.....	.....	.....	.....
California..........	34	18	52	30	14	44	1	2	3	3	2	5
Colorado..........	.....	4	4	.....	3	3	.....	.....	.....	.....	1	1
Connecticut........	4	.....	4	.....	.....	.....	.....	.....	.....	4	.....	4
Dist. of Columbia...	3	.....	3	.....	.....	.....	3	.....	3	.....	.....	.....
Florida............	4	3	7	4	3	7	.....	.....	.....	.....	.....	.....
Georgia...........	10	4	14	.....	.....	.....	.....	.....	.....	10	4	14
Illinois............	60	28	88	56	22	78	.....	.....	.....	4	6	10
Indiana............	2	.....	2	2	.....	2	.....	.....	.....	.....	.....	.....
Iowa..............	5	9	14	1	6	7	4	3	7	.....	.....	.....
Kansas............	1	1	2	1	1	2	.....	.....	.....	.....	.....	.....
Kentucky..........	2	.....	2	.....	.....	.....	.....	.....	.....	2	.....	2
Louisiana..........	24	1	25	2	1	3	.....	.....	.....	22	.....	22
Maine.............	1	2	3	1	2	3	.....	.....	.....	.....	.....	.....
Maryland..........	4	9	13	.....	3	3	.....	1	1	4	5	9
Massachusetts......	1	2	3	.....	.....	.....	.....	.....	.....	1	2	3
Michigan..........	12	13	25	11	9	20	.....	2	2	1	2	3
Minnesota.........	2	3	5	.....	.....	.....	.....	.....	.....	2	3	5
Mississippi.........	10	4	14	10	4	14	.....	.....	.....	.....	.....	.....
Missouri...........	23	10	33	9	6	15	.....	.....	.....	14	4	18
Montana...........	22	4	26	22	4	26	.....	.....	.....	.....	.....	.....
Nebraska..........	5	2	7	5	2	7	.....	.....	.....	.....	.....	.....
New Jersey........	7	1	8	3	1	4	1	.....	1	3	.....	3
New York.........	107	49	156	.....	.....	.....	8	10	18	99	39	138
North Carolina.....	9	6	15	.....	.....	.....	.....	.....	.....	9	6	15
Ohio..............	13	9	22	8	6	14	4	2	6	1	1	2
Oklahoma..........	31	12	43	3	3	6	.....	.....	.....	28	9	37
Oregon............	4	3	7	2	1	3	.....	.....	.....	2	2	4
Pennsylvania.......	22	15	37	.....	.....	.....	1	3	4	21	12	33
Tennessee..........	30	17	47	5	4	9	10	9	19	15	4	19
Texas.............	25	11	36	.....	.....	.....	.....	.....	.....	25	11	36
Utah..............	1	1	2	1	1	2	.....	.....	.....	.....	.....	.....
Vermont...........	22	12	34	9	3	12	.....	.....	.....	13	9	22
Virginia...........	10	3	13	3	2	5	.....	.....	.....	7	1	8
West Virginia......	6	1	7	6	1	7	.....	.....	.....	.....	.....	.....
Wisconsin..........	2	4	6	1	2	3	.....	2	2	1	.....	1
U. S. Public Health Service hospitals..	12	.....	12	.....	.....	.....	12	.....	12	.....	.....	.....

Table VI—Increase in number of patients with mental disease in institutions in the several states of the Union, from January 1, 1910, to January 1, 1920, compared with increase of general population

STATE	PATIENTS WITH MENTAL DISEASE												Per cent increase of general population from 1910 to 1920
	JANUARY 1, 1910			JANUARY 1, 1920			INCREASE FROM 1910 TO 1920						
							NUMBER			PER CENT			
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	
United States	98,695	89,096	187,791	121,031†	111,649	232,680†	22,336	22,553	44,889	22.6	25.3	23.9	14.9
Alabama	981	1,058	2,039	1,066	1,172	2,238	85	114	199	8.7	10.8	9.8	9.8
Arizona	265	72	337	335	134	469	70	62	132	26.4	86.1	39.2	63.4
Arkansas	529	563	1,092	737	719	1,456	208	156	364	39.3	27.7	33.3	11.3
California	4,115	2,537	6,652	5,823	4,361	10,184	1,708	1,824	3,532	41.5	71.9	53.1	44.1
Colorado	687	512	1,199	926	754	1,680	239	242	481	34.8	47.3	40.1	17.6
Connecticut	1,680	1,899	3,579	2,134	2,253	4,387	454	354	808	27.0	18.6	22.6	23.9
Delaware	237	204	441	256	235	491	19	31	50	8.0	15.2	11.3	10.2
Dist. of Columbia	2,170	720	2,890	2,494	848	3,342	324	128	452	14.9	17.8	15.6	32.2
Florida	446	403	849	638	588	1,226	192	185	377	43.0	45.9	44.4	28.7
Georgia	1,531	1,601	3,132	1,831	1,923	3,754	300	322	622	19.6	20.1	19.9	11.0
Idaho	256	132	388	349	196	545	93	64	157	36.3	48.5	40.5	32.6
Illinois	6,846	5,993	12,839	7,794	7,090	14,884	948	1,097	2,045	13.8	18.3	15.9	15.0
Indiana	2,235	2,292	4,527	2,866	2,733	5,599	631	441	1,072	28.2	19.2	23.7	8.5
Iowa	2,896	2,481	5,377	3,219	2,745	5,964	323	264	587	11.2	10.6	10.9	8.1
Kansas	1,694	1,218	2,912	1,699	1,355	3,054	5	137	142	0.3	11.2	4.9	4.6
Kentucky	1,968	1,570	3,538	2,249	1,905	4,154	281	335	616	14.3	21.3	17.4	5.5
Louisiana	1,070	1,088	2,158	1,131	1,220	2,351	61	132	193	5.7	12.1	8.9	8.6
Maine	693	565	1,258	821	826	1,647	128	261	389	18.5	46.2	30.9	3.5
Maryland	1,569	1,651	3,220	1,845	2,128	3,973	276	477	753	17.6	28.9	23.4	11.9

Massachusetts	5,633	5,968	11,601	6,993	7,406	14,399	1,360	1,438	2,798	24.1	24.1	24.1	14.4
Michigan	3,679	3,020	6,699	4,129	3,604	7,733	450	584	1,034	12.2	19.3	15.4	30.5
Minnesota	2,755	1,989	4,744	3,396	2,568	5,964	641	579	1,220	23.3	29.1	25.7	15.0
Mississippi	933	1,045	1,978	801	1,008	1,809	132*	37*	169*	14.1*	3.5*	8.5*	0.4*
Missouri	3,231	2,937	6,168	3,468	3,478	6,946	237	541	778	7.3	18.4	12.6	3.4
Montana	531	166	697	733	369	1,102	202	203	405	38.0	122.3	58.1	46.0
Nebraska	1,141	849	1,990	1,478	1,146	2,624	337	297	634	29.5	35.0	31.9	8.7
Nevada	165	65	230	159	61	220	6*	4*	10*	3.6*	6.2*	4.3*	5.5*
New Hampshire	463	446	909	605	618	1,223	142	172	314	30.7	38.6	34.5	2.9
New Jersey	2,913	3,129	6,042	3,507	3,891	7,398	594	762	1,356	20.4	24.4	22.4	24.4
New Mexico	128	91	219	206	150	356	78	59	137	60.9	64.8	62.6	10.1
New York	14,955	16,325	31,280	18,480	20,423	38,903	3,525	4,098	7,623	23.6	25.1	24.4	13.9
North Carolina	1,032	1,490	2,522	1,343	1,837	3,180	311	347	658	30.1	23.3	26.1	16.0
North Dakota	407	221	628	801	442	1,243	394	221	615	96.8	100.0	97.9	11.9
Ohio	5,615	4,979	10,594	6,483	5,734	12,217	868	755	1,623	15.5	15.2	15.3	20.8
Oklahoma	651	459	1,110	1,068	922	1,990	417	463	880	64.1	100.9	79.3	22.4
Oregon	1,088	477	1,565	1,617	820	2,437	529	343	872	48.6	71.9	55.7	16.4
Pennsylvania	7,919	7,139	15,058	9,924	8,840	18,764	2,005	1,701	3,706	25.3	23.8	24.6	13.8
Rhode Island	650	593	1,243	794	734	1,528	144	141	285	22.2	23.8	22.9	11.4
South Carolina	708	833	1,541	917	977	1,894	209	144	353	29.5	17.3	22.9	11.1
South Dakota	535	329	864	692	490	1,182	157	161	318	29.3	48.9	36.8	9.0
Tennessee	1,057	1,147	2,204	1,197	1,408	2,605	140	261	401	13.2	22.8	18.2	7.0
Texas	2,087	1,966	4,053	2,697	2,889	5,586	610	923	1,533	29.2	46.9	37.8	19.7
Utah	171	171	342	291	243	534	120	72	192	70.2	42.1	56.1	20.4
Vermont	528	462	990	552	543	1,095	24	81	105	4.5	17.5	10.6	1.0*
Virginia	1,779	1,856	3,635	2,133	2,117	4,250	354	261	615	19.9	14.1	16.9	12.0
Washington	1,325	662	1,987	2,118	1,305	3,423	793	643	1,436	59.8	97.1	72.3	18.8
West Virginia	900	822	1,722	977	831	1,808	77	9	86	8.6	1.1	5.0	19.9
Wisconsin	3,743	2,844	6,587	4,382	3,530	7,912	639	686	1,325	17.1	24.1	20.1	12.8
Wyoming	105	57	162	168	80	248	63	23	86	60.0	40.4	53.1	33.2

* Decrease.

† Includes 709 patients in United States Public Health Service hospitals.

Table VII—Patients with mental disease in institutions in the United States by divisions and states, with rates per 100,000 of general population, on January 1 of 1910 and 1920

STATE	NUMBER		RATE PER 100,000 OF GENERAL POPULATION	
	1910	1920*	1910	1920
United States	187,791	232,680	204.2	220.1
New England	19,580	24,279	298.8	328.1
Maine	1,258	1,647	169.5	214.4
New Hampshire	909	1,223	211.1	276.0
Vermont	990	1,095	278.1	310.7
Massachusetts	11,601	14,399	344.6	373.8
Rhode Island	1,243	1,528	229.1	252.8
Connecticut	3,579	4,387	321.1	317.8
Middle Atlantic	52,380	65,065	271.2	292.3
New York	31,280	38,903	343.2	374.6
New Jersey	6,042	7,398	238.1	234.4
Pennsylvania	15,058	18,764	196.4	215.2
East North Central	41,246	48,345	226.0	225.1
Ohio	10,594	12,217	222.2	212.1
Indiana	4,527	5,599	167.6	191.1
Illinois	12,839	14,884	227.7	229.5
Michigan	6,699	7,733	238.4	210.8
Wisconsin	6,587	7,912	282.2	300.6
West North Central	22,683	26,977	194.9	215.1
Minnesota	4,744	5,964	228.5	249.8
Iowa	5,377	5,964	241.7	248.1
Missouri	6,168	6,946	187.3	204.1
North Dakota	628	1,243	108.8	192.5
South Dakota	864	1,182	148.0	185.7
Nebraska	1,990	2,624	166.9	202.4
Kansas	2,912	3,054	172.2	172.6
South Atlantic	19,952	23,918	163.6	171.0
Delaware	441	491	218.0	220.2
Maryland	3,220	3,973	248.6	274.1
Dist. of Columbia	2,890	3,342	872.9	763.8
Virginia	3,635	4,250	176.3	184.0
West Virginia	1,722	1,808	141.0	123.5
North Carolina	2,522	3,180	114.3	124.3
South Carolina	1,541	1,894	101.7	112.5
Georgia	3,132	3,754	120.0	129.6
Florida	849	1,226	112.8	126.9
East South Central	9,759	10,806	116.0	121.5
Kentucky	3,538	4,154	154.5	171.9
Tennessee	2,204	2,605	100.9	111.4
Alabama	2,039	2,238	95.4	95.3
Mississippi	1,978	1,809	110.1	101.0

Table VII—Patients with mental disease in institutions in the United States by divisions and states, with rates per 100,000 of general population, on January 1 of 1910 and 1920—Concluded

STATE	NUMBER		RATE PER 100,000 OF GENERAL POPULATION	
	1910	1920*	1910	1920
West South Central	8,413	11,383	95.8	111.1
Arkansas	1,092	1,456	69.4	83.1
Louisiana	2,158	2,351	130.3	130.7
Oklahoma	1,110	1,990	67.0	98.1
Texas	4,053	5,586	104.0	119.8
Mountain	3,574	5,154	135.7	154.5
Montana	697	1,102	185.3	200.8
Idaho	388	545	119.2	126.2
Wyoming	162	248	111.0	127.6
Colorado	1,199	1,680	150.1	178.8
New Mexico	219	356	66.9	98.8
Arizona	337	469	164.9	140.5
Utah	342	534	91.6	118.8
Nevada	230	220	280.9	284.2
Pacific	10,204	16,044	243.4	288.2
Washington	1,987	3,423	174.0	252.3
Oregon	1,565	2,437	232.6	311.1
California	6,652	10,184	279.8	297.2

* Includes 709 patients in United States Public Health Service hospitals.

Table VIII—Patients with mental disease in institutions in the several states of the Union, with rates per 100,000 of general population, in 1890, 1904, 1910, and 1920

STATE	JUNE 1, 1890		JANUARY 1, 1904		JANUARY 1, 1910		JANUARY 1, 1920	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
United States	106,485	170.0	150,151	183.6	187,791	204.2	232,680*	220.1
Alabama	1,469	97.1	1,603	82.6	2,039	95.4	2,238	95.3
Arizona	64	107.3	224	146.9	337	164.9	469	140.5
Arkansas	790	70.0	667	47.4	1,092	69.4	1,456	83.1
California	3,736	309.2	5,717	316.0	6,652	279.8	10,184	297.2
Colorado	326	79.1	754	119.0	1,199	150.1	1,680	178.8
Connecticut	2,056	275.5	2,831	287.9	3,579	321.1	4,387	317.8
Delaware	197	116.9	353	184.7	441	218.0	491	220.2
Dist. of Columbia	1,578	684.9	2,453	823.9	2,890	872.9	3,342	763.8
Florida	351	89.7	713	116.9	849	112.8	1,226	126.9
Georgia	1,815	98.8	2,839	120.4	3,132	120.0	3,754	129.6
Idaho	83	98.4	255	115.3	388	119.2	545	126.2
Illinois	6,641	173.6	9,607	187.7	12,839	227.7	14,884	229.5
Indiana	3,291	150.1	4,358	168.7	4,527	167.6	5,599	191.1
Iowa	3,197	167.2	4,385	196.7	5,377	241.7	5,964	248.1
Kansas	1,794	125.7	2,460	158.7	2,912	172.2	3,054	172.6
Kentucky	2,729	146.8	3,058	139.1	3,538	154.5	4,154	171.9
Louisiana	910	81.4	1,585	107.0	2,158	130.3	2,351	130.7
Maine	1,299	196.5	885	124.3	1,258	169.5	1,647	214.4
Maryland	1,646	157.9	2,505	204.2	3,220	248.6	3,973	274.1
Massachusetts	6,103	272.6	8,679	288.4	11,601	344.6	14,399	373.8
Michigan	3,725	177.9	5,430	211.9	6,699	238.4	7,733	210.8
Minnesota	2,205	169.4	4,070	217.8	4,744	228.5	5,964	249.8
Mississippi	1,104	85.6	1,493	91.0	1,978	110.1	1,809	101.0
Missouri	3,418	127.6	5,103	160.8	6,168	187.3	6,946	204.1
Montana	192	145.3	543	186.3	697	185.3	1,102	200.8
Nebraska	932	88.0	1,536	138.1	1,990	166.9	2,624	202.4
Nevada	183	399.9	200	352.8	230	280.9	220	284.2
New Hampshire	961	255.2	496	118.5	909	211.1	1,223	276.0
New Jersey	3,163	218.9	4,865	229.4	6,042	238.1	7,398	234.4
New Mexico	66	43.0	113	46.5	219	66.9	356	98.8
New York	17,846	297.5	26,176	329.7	31,280	343.2	38,903	374.6
North Carolina	1,725	106.6	1,883	93.8	2,522	114.3	3,180	124.3
North Dakota	221	121.0	446	108.1	628	108.8	1,243	192.5
Ohio	7,600	207.0	8,621	196.9	10,594	222.2	12,217	212.1
Oklahoma	7	11.3	413	37.4	1,110	67.0	1,990	98.1
Oregon	640	204.0	1,285	253.2	1,565	232.6	2,437	311.1
Pennsylvania	8,482	161.3	11,521	169.5	15,058	196.4	18,764	215.2
Rhode Island	795	230.1	1,077	229.2	1,243	229.1	1,528	252.8
South Carolina	912	79.2	1,156	82.3	1,541	101.7	1,894	112.5
South Dakota	310	94.3	595	127.2	864	148.0	1,182	185.7
Tennessee	1,845	104.4	1,713	82.3	2,204	100.9	2,605	111.4
Texas	1,670	74.7	3,345	99.7	4,053	104.0	5,586	119.8
Utah	166	79.8	344	110.3	342	91.6	534	118.8
Vermont	823	247.6	887	254.8	990	278.1	1,095	310.7
Virginia	2,407	145.4	3,137	162.6	3,635	176.3	4,250	184.0
Washington	380	108.8	1,178	158.2	1,987	174.0	3,423	252.3
West Virginia	1,079	141.5	1,475	139.9	1,722	141.0	1,808	123.5
Wisconsin	3,513	208.3	5,023	232.0	6,587	282.2	7,912	300.6
Wyoming	40	65.9	96	85.8	162	111.0	248	127.6

*Includes 709 patients in United States Public Health Service hospitals.

Table IX—Patients with mental disease in state institutions, and absent from institutions but still on books, in the several states of the Union, January 1, 1920

STATE	IN STATE INSTITUTIONS			ABSENT FROM INSTITUTIONS BUT STILL ON BOOKS			Per cent absent of total on books
	M.	F.	T.	M.	F.	T.	
United States	105,134	94,975	200,109	9,381	8,887	18,268	9.1
Alabama	1,065	1,171	2,236	156	147	303	11.9
Arizona	335	134	469	7	4	11	2.3
Arkansas	737	719	1,456	355	345	700	32.5
California	5,688	4,240	9,928	542	526	1,068	9.7
Colorado	872	702	1,574	108	79	187	10.6
Connecticut	1,965	1,946	3,911	92	110	202	4.9
Delaware	256	235	491	8	8	16	3.2
Dist. of Columbia	2,436	845	3,281	86	40	126	3.7
Florida	638	588	1,226	......	......	......	......
Georgia	1,806	1,881	3,687	102	92	194	5.0
Idaho	349	196	545	34	18	52	8.7
Illinois	7,675	6,910	14,585	416	330	746	4.9
Indiana	2,747	2,630	5,377	186	198	384	6.7
Iowa	2,421	1,878	4,299	469	453	922	17.7
Kansas	1,679	1,331	3,010	154	140	294	8.9
Kentucky	2,230	1,887	4,117	129	100	229	5.3
Louisiana	1,035	1,051	2,086	17	5	22	1.0
Maine	813	812	1,625	114	111	225	12.2
Maryland	1,326	1,328	2,654	......	......	......	......
Massachusetts	6,840	7,122	13,962	893	1,081	1,974	12.4
Michigan	3,599	2,875	6,474	*	*	*	*
Minnesota	3,367	2,531	5,898	450	391	841	12.5
Mississippi	801	1,008	1,809	28	40	68	3.6
Missouri	2,339	2,020	4,359	157	83	240	5.2
Montana	733	369	1,102	*	*	*	*
Nebraska	1,446	1,110	2,556	112	111	223	8.0
Nevada	159	61	220	6	7	13	5.6
New Hampshire	605	618	1,223	35	42	77	5.9
New Jersey	2,151	2,110	4,261	81	99	180	4.1
New Mexico	206	150	356	48	21	69	16.2
New York	18,004	19,493	37,497	1,158	1,275	2,433	6.1
North Carolina	1,320	1,795	3,115	226	216	442	12.4
North Dakota	801	442	1,243	89	67	156	11.2
Ohio	6,370	5,568	11,938	644	546	1,190	9.1
Oklahoma	1,004	840	1,844	8	3	11	0.6
Oregon	1,422	783	2,205	78	115	193	8.0
Pennsylvania	5,100	4,148	9,248	322	271	593	6.0
Rhode Island	729	670	1,399	158	142	300	17.7
South Carolina	915	965	1,880	68	59	127	6.3
South Dakota	692	490	1,182	1	3	4	0.3
Tennessee	967	1,136	2,103	39	42	81	3.7
Texas	2,619	2,789	5,408	294	354	648	10.7
Utah	291	243	534	1	1	2	0.4
Vermont	338	354	692	9	......	9	1.3
Virginia	2,125	2,102	4,227	339	313	652	13.4
Washington	2,113	1,295	3,408	243	144	387	10.2
West Virginia	977	831	1,808	216	254	470	20.6
Wisconsin	860	493	1,353	688	493	1,181	46.6
Wyoming	168	80	248	15	8	23	8.5

*Unascertained.

Table X—Increase in number of mental defectives in institutions in the several states of the Union, from January 1, 1910, to January 1, 1920, with rates per 100,000 of general population

STATE	MENTAL DEFECTIVES IN INSTITUTIONS						Rate per 100,000 of general population	
	JANUARY 1, 1910			JANUARY 1, 1920				
	M.	F.	T.	M.	F.	T.	1910	1920
United States	11,015	9,716	20,731	20,123	20,396	40,519	22.5	38.3
Alabama	......	......	......	11	18	29	......	1.2
Arizona	......	......	......	18	14	32	......	9.6
Arkansas	......	......	......	75	75	150	......	8.6
California	470	384	854	474	491	965	35.9	28.2
Colorado	39	25	64	163	102	265	8.0	28.2
Connecticut	156	138	294	247	221	468	26.4	33.9
Delaware	......	......	......	......	......	......	......	......
Dist. of Columbia	......	......	......	5	1	6	......	1.4
Florida	......	......	......	79	73	152	......	15.7
Georgia	......	......	......	6	......	6	......	0.2
Idaho	......	......	......	63	51	114	......	26.4
Illinois	718	547	1,265	1,677	1,470	3,147	22.4	48.5
Indiana	518	617	1,135	582	682	1,264	42.0	43.1
Iowa	619	570	1,189	860	844	1,704	53.4	70.9
Kansas	237	183	420	359	372	731	24.8	41.3
Kentucky	167	116	283	337	304	641	12.4	26.5
Louisiana	......	......	......	234	194	428	......	23.8
Maine	49	13	62	229	203	432	8.4	56.2
Maryland	151	159	310	463	495	958	23.9	66.1
Massachusetts	879	585	1,464	1,678	1,514	3,192	43.5	82.9
Michigan	518	468	986	990	859	1,849	35.1	50.4
Minnesota	628	566	1,194	764	738	1,502	57.5	62.9
Mississippi	......	......	......	79	57	136	......	7.6
Missouri	233	279	512	525	522	1,047	15.5	30.8
Montana	30	21	51	86	44	130	13.6	23.7
Nebraska	235	211	446	359	323	682	37.4	52.6
Nevada	......	......	......	2	......	2	......	2.6
New Hampshire	70	74	144	150	164	314	33.4	70.9
New Jersey	296	344	640	709	1,053	1,762	25.2	55.8
New Mexico	......	......	......	......	......	......	......	......
New York	1,685	1,736	3,421	2,660	3,102	5,762	37.5	55.5
North Carolina	......	......	......	74	97	171	......	6.7
North Dakota	79	66	145	118	96	214	25.1	33.1
Ohio	810	716	1,526	1,211	1,224	2,435	32.0	42.3
Oklahoma	......	......	......	297	237	534	......	26.3
Oregon	......	......	......	216	259	475	......	60.6
Pennsylvania	1,598	1,107	2,705	2,147	2,134	4,281	35.3	49.1
Rhode Island	48	......	48	148	163	311	8.8	51.5
South Carolina	......	......	......	85	70	155	......	9.2
South Dakota*	......	......	......	194	152	346	......	54.4
Tennessee	25	22	47	83	86	169	2.2	7.2
Texas	9	10	19	70	154	224	0.5	4.8
Utah	45	......	45	29	40	69	12.1	15.4
Vermont	......	......	......	44	83	127	......	36.0
Virginia	29	31	60	144	264	408	2.9	17.7
Washington	90	69	159	331	275	606	13.9	44.7
West Virginia	116	98	214	197	185	382	17.5	26.1
Wisconsin	468	561	1,029	760	864	1,624	44.1	61.7
Wyoming	......	......	......	43	27	70	......	36.0
U. S. Public Health Service hospitals	......	......	......	48	......	48	......	......

*No report for 1910.

Table XI—Neuropsychiatric patients in United States Public Health Service hospitals, January 1, 1920

HOSPITAL	Total	With mental disease	Epileptics	Mental defectives	Alcoholics	Drug addicts	Nervous cases
No. 1. Baltimore, Md	15	.....	1	2	.....	.....	12
No. 2. Boston, Mass	17	3	6	.....	.....	.....	8
No. 3. Buffalo, N. Y	3	1	2	.....	.....	.....	......
No. 5. Chicago, Ill	20	2	1	1	.....	.....	16
No. 6. Cleveland, O	5	3	.....	.....	.....	1	1
No. 7. Detroit, Mich	13	4	2	.....	.....	3	4
No. 8. Evansville, Ind	2	.....	.....	1	.....	1	......
No. 11. Louisville, Ky	5	.....	.....	.....	.....	.....	5
No. 12. Memphis, Tenn	5	.....	1	.....	.....	2	2
No. 13. Mobile, Ala	9	.....	2	4	.....	.....	3
No. 16. Portland, Me	1	1	.....	.....	.....	.....	......
No. 17. Port Townsend, Wash	10	.....	1	.....	.....	.....	9
No. 19. San Francisco, Cal	4	1	.....	.....	.....	.....	3
No. 21. Stapleton, N. Y	21	9	1	1	2	.....	8
No. 22. Vineyard Haven, Mass	1	1	.....	.....	.....	.....	......
No. 24. Palo Alto, Cal	29	.....	3	1	.....	1	24
No. 28. Dansville, N. Y	256	256	.....	.....	.....	.....	......
No. 29. Norfolk, Va	1	.....	1	.....	.....	.....	......
No. 30. Chicago, Ill	20	2	2	4	.....	.....	12
No. 32. Washington, D. C	5	.....	1	1	.....	.....	3
No. 34. East Norfolk, Mass	68	1	57	.....	.....	.....	10
No. 35. St. Louis, Mo	68	37	7	5	2	1	16
No. 37. Waukesha, Wis	90	3	.....	2	1	1	83
No. 38. New York City	17	.....	2	1	.....	.....	14
No. 39. Hoboken, Pa	274	261	1	5	.....	.....	7
No. 40. Cape May, N. J	140	46	2	14	.....	.....	78
No. 41. New Haven, Conn	22	6	1	6	.....	.....	9
No. 43. Ellis Island, New York City	30	29	.....	.....	.....	1	......
No. 44. West Roxbury, Mass	58	42	4	.....	.....	.....	12
No. 45. Biltmore, N. C	8	1	3	.....	1	1	2
Total	1,217	709	101	48	6	12	341

ABSTRACTS

Out-Patient Psychiatry. By Abraham Myerson, M.D. *The American Journal of Insanity,* 77:47-74, July, 1920.

It is impossible in an abstract to give more than the merest outline of the valuable material contained in this article, in which Dr. Myerson discusses the data of the Out-Patient Department of the Psychopathic Department of the Boston State Hospital, from October 1918 to September 1919 inclusive. The questions that come up in connection with the work of the Out-Patient Department are grouped under four general heads: First, who sends the patients? Second, what problems do they present? Third, what are the diagnoses reached? Fourth, what is done with the patients?

The total number of new patients—adults, adolescents, children, and infants—received at the Out-Patient Department during the year in question was 1,577—664 males and 913 females. This preponderance of females over males Dr. Myerson considers a social rather than a biological matter. The excess of females occurs in the adult and adolescent classes, which are referable to two sources—the social agencies and psychoneurotics who come of their own initiative. As there are more social agencies interested in adult and adolescent females than in males of the same ages, more females than males are received from this source. Also, in the care of the psychoneurotics, more women than men have the leisure to come for treatment. On the other hand, the preponderance of male over female children—253 of the former to 148 of the latter—is in Dr. Myerson's opinion biological rather than social. "The preponderance is largely in the greater number of mentally deficient and delinquent boys sent in by the schools and the courts for examination."

Of the 1,577 patients, the greatest number—391—were sent by the social agencies, closely followed by those who came of their own initiative or through the initiative of relatives—301. One hundred and eighty-four (presenting mainly the problem of neurosyphilis) were sent by the Social Service Department of the Psychopathic Hospital, 165 from the wards of the Psychopathic Department, and 182 by physicians. The courts, the Red Cross, and the schools sent 80, 56, and 55 respectively; other hospitals 163.

As to the types of problems presented, the largest single group of cases was made up of the backward children, of whom there were 273. Next in numerical importance came the group of suspected insane persons (259) and the group of psychoneurotics (199). The families of syphilitic patients in the wards of the Psychopathic Department made up another large group—170. Delinquents, after-care patients—mainly discharged from the wards of the hospital—epileptics, and cases of neurological condition were other types.

More detailed tables give the diagnosis and disposition of the cases from each source. In the groups sent by the courts, the schools, the social agencies, the Red Cross, and the other hospitals, mental deficiency held first rank; in the large group sent by the social agencies, over 50 per cent of the cases were suffering from some form of mental deficiency. There was little mental deficiency in the group sent by the doctors, which, since mental deficiency is largely a social problem, seems to indicate that the doctors are interested in the medical rather than in the social aspect of their cases. This view is borne out by the fact that the numbers of male and of female patients sent by the doctors were about equal. Nearly one-third of this group were cases of mental disease. The group sent from the wards of the Psychopathic Hospital was made up principally of patients who had been received as temporary-care or voluntary patients for a period ranging from 10 days to several months and then been discharged to the Out-patient Department as relieved or improved. There were 36 cases of dementia praecox in this group. This may seem curious in view of the present conception of dementia praecox as an incurable disorder, but is accounted for by the fact that in the majority of these cases the disease was not so marked as to make it no longer safe to allow the patient to remain in the community. Mental deficiency occurred only 5 times in this group; the majority of the cases of mental deficiency seen in the wards are either referred back to the social agencies that sent them or recommended to schools for feebleminded. In the group sent by the Social Service Department of the Psychopathic Hospital, consisting largely of families of syphilitics, 16 of the 184 individuals examined were cases of conjugal syphilis, a large number in view of the fact that the majority of the persons examined complained of no particular trouble. There were only 5 cases of congenital syphilis, which would seem to show that the danger to the wife is greater than that to the child. The cases that came through their own initiative or the initiative of relatives were largely psychoneurotics, the majority of them women, among them a noteworthy number of Jews. This Dr. Myerson attributes to the fact that the Jews are not afraid of the term psychopathic and, because of their intimate communal life, are more likely to send one another for treatment.

In closing, Dr. Myerson discusses, from the standpoint of the out-patient department, some of the types encountered there—the psychoneuroses, mental deficiency, delinquency—and makes a plea for the abandonment of the terms insanity and psychosis in medical discussions, as tending to obscurity. It would, in his opinion, simplify matters if each case were regarded from two angles—"First, what type of disease does this case present—feeblemindedness, hysteria, general paresis, dementia praecox, or anything else in the psychiatric classification groups; second, does this patient need commitment or can he be cared for in the community?"

THE CRIMINOLOGIST AND THE COURTS. By Herman M. Adler. *Journal of Criminal Law and Criminology,* 11:419-425, November, 1920.

Dr. Adler discusses here briefly three of the more important personality types encountered in the study of criminology—the paranoid or egocentric personality, the defective delinquent, and the psychopathic criminal—and some of the problems that come up in connection with them. Cases of these types will, in his opinion, present difficulties so long as the criminal law deals with them on the basis of responsibility and on the basis of property damage; they are personality problems and as such cannot be dealt with on the basis of property valuation. He recommends three changes in the present system of criminal law: 1. that criminals and delinquents shall be committed not to definite institutions, but to the guardianship of the State, to be under the scientific direction of trained criminologists; 2. that the treatment of prisoners shall be based upon a study of their individual needs, and that the duration of treatment shall depend upon their progress toward normality; 3. that criminals, feebleminded, insane, and dependents shall be legally declared minors until they are able to prove that they have reached a state of maturity equivalent to adult age and are capable of managing their own affairs.

THE EFFECTS OF SYPHILIS ON THE FAMILIES OF SYPHILITICS SEEN IN THE LATE STAGES. By Harry C. Solomon, M.D., and Maida H. Solomon. *Social Hygiene,* 6:469-87, October, 1920.

For the last five years it has been a routine procedure at the Boston Psychopathic Hospital to examine the families of all patients with a positive Wassermann reaction. Since this clinic deals primarily, not with syphilitics, but with cases of involvement of the central nervous system, practically all these patients have been late syphilitics. The patients were divided into three groups—cases of general paresis, of cerebro-spinal syphilis, and of late syphilis without involvement of the nervous system, this division being made for the purpose of determining whether cases in which there is involvement of the central nervous system present a different family problem from those in which the central nervous system escapes. During the five years, 555 families have been thus examined. This paper is a thorough study of the findings of the examinations, from which the authors draw the following conclusions:

"1. The family of the late syphilitic abounds with evidence of syphilitic damage.

"2. At least one-fifth of the families of syphilitics have one or more syphilitic members in addition to the original patient.

"3. Between one-third and one-fourth of the families of syphilitics have never given birth to a living child. This is much larger than the percentage obtained from the study of a large group of New England families taken at random, which shows that only one-tenth were childless.

"4. More than one-third of the families of syphilitics have accidents to pregnancies; namely, abortions, miscarriages, or stillbirths.

"5. The birth rate in syphilitic families is 2.05 per family; whereas the birth rate in the New England families mentioned above is 3.8 per family, or almost twice as great.

"6. Two-thirds of the families show defects as to children (sterility, accidents to pregnancies, and syphilitic children).

"7. Only one-third of the families show no defect as to children or Wassermann reaction in spouse.

"8. About one-fifth of the individuals examined show a positive Wassermann reaction; more of these are spouses than children.

"9. Between one-fourth and one-third of the spouses examined show syphilitic involvement.

"10. Between one in twelve and one in six of the children examined show syphilitic involvement.

"11. One-fifth of all children born alive in syphilitic families were dead at the time the families were examined. This does not differ materially from the general average in the community.

"12. One-fifth of the pregnancies are abortions, miscarriages, or stillbirths, compared with less than one-tenth of the pregnancies in non-syphilitic families.

"13. The average pregnancies per family is 2.58, compared with 3.88, 4.43, and 5.51 in non-syphilitic families.

"14. There are 3.52 stillbirths per 100 live births in the syphilitic families, as compared with the 3.79 reported by the Massachusetts census, showing that there is no very marked difference in this regard.

"15. A syphilitic is a syphilitic, whether his disease is general paresis, cerebro-spinal syphilis, or visceral syphilis without involvement of the central nervous system, and the problems affecting his family are the same in any case.

"The family of every syphilitic patient should be examined, irrespective of the stage of the disease or the symptomatology presented by the patient when first seen. If this is done, cases of conjugal and congenital syphilis will be discovered which would otherwise be neglected. They will often be found at a period when symptoms are not active, and thus treatment may be instituted before irreparable destructive lesions have occurred. An opportunity is offered to prevent the development of such disabling conditions as general paresis, tabes dorsalis, aneurysms, and the like. The possibility of bearing healthy children may be increased. Every clinic dealing with syphilitic patients, whether it is primarily a syphilitic clinic, a neurological clinic, a cardiac clinic, or an internal-medicine clinic should be equipped with the machinery for bringing the members of the syphilitic's family to the clinic for examination."

THE AIR MEDICAL SERVICE AND THE FLIGHT SURGEON. By Lieutenant Colonel L. H. Bauer and Major William MacLake. *The Military Surgeon,* 46:40-50, January, 1920.

The establishment of the Air Medical Service as a separate branch of the Surgeon General's Office and the development of the medical officer known as the flight surgeon were due to a recognition of the fact that the medical problems of aviation are entirely different from those of any other service. The work of the Air Medical Service has three phases: (1) the selection of the flier, (2) the classification of the flier, (3) the maintenance of the flier. In selecting the flier, the standard physical examination for entrance into the army is not sufficient. Certain special tests of the eyes and ears are necessary to determine the presence of defects that are of slight importance in the case of a candidate for any other branch of the service, but that would seriously interfere with the efficiency of the aviator. These tests should be given, not necessarily by a specialist, but by a medical officer who has had special training in the making of such examinations. The same thing is true of the personality study that is made of each candidate, for the purpose (1) of detecting nervous and mental diseases that might render him temporarily or permanently unfit for the service; (2) of forming a definite idea as to how he will stand the strain upon arriving at the front; and (3) of determining and as far as possible compensating for the existence of latent tendencies that might become so accentuated, under the stress of actual warfare, as to render him inefficient and increase the danger of a nervous and mental collapse. The vital importance of this personality study may be judged from the fact that, aside from the disability resulting from epidemics, probably 70 per cent of the cases of lowered efficiency among aviators are due to the condition called "staleness"—a break, either partial or complete, in the nervous system.

Classification of the selected applicants is based upon the results of tests with the rebreathing machine—an apparatus by means of which it is possible to determine the physical and psychological effects of a constantly diminishing supply of oxygen. The grading is into four classes: Class D are grounded as totally unfit to fly; Class C are allowed to fly up to 10,000 feet, Class B up to 15,000, and Class A to any altitude.

In the third phase of the work—the maintenance of the flier—the flight surgeon is the chief factor. He should himself be a flier and a specialist in the care of fliers, and he should live in as close touch with his men as possible, mingling with them at mess, in quarters, and during recreation time, studying them as individuals and becoming their confidant and adviser. He will thus be in a position to detect the first faint signs of lowered efficiency in his men and by treating them in time will often prevent accidents or serious breakdowns.

REËDUCATION OF DEMENTED PATIENTS. By W. A. Bryan, M.D. *The American Journal of Insanity,* 77:99-111, July, 1920.

For the past eighteen months the Danvers State Hospital has been carrying on an experiment in the rehabilitation of the class of chronic demented patients by means of occupational therapy. The experiment was undertaken on the theory that the degeneration of these patients to the filthy, destructive stage of their disease is largely due to habit deterioration, and that much can be done by special training either to prevent the formation of vicious habits or to form new and better habits in those who have already deteriorated.

The first step is the approach to the patient. This has been found to be largely a matter of trial and error. It consists of calling into activity some one of the following primary instincts—"play, imitation, acquisitiveness and constructiveness, affection, sympathy, self-assertion, curiosity, rivalry, pugnacity in certain cases, and occasionally the sex instincts, as expressed in modesty and vanity." The possibility of substituting one of these instincts for the more vicious instinct—fear, for instance—that is dominating the patient is the basis of whatever success is to be attained in the reëducation of psychotic patients. The best opening is usually through the play instinct. "There are several reasons for this. It is accompanied by the emotion of pleasure, and thus is valuable in itself. It is stimulating to the imagination, thus developing intelligence, and by an almost imperceptible gradation it can be transformed into useful work without any diminution in the affective coloring."

In directing and modifying the patient's reactions to the newly stimulated instinct into new and better habits, to take the place of the vicious habits that have resulted from prolonged reaction to the old dominating instinct, certain important considerations must be kept in mind: (1) the incentive to the formation of the new habit must be strong as possible, varying according to the requirements of the individual case from judicious praise to the hope of additional privileges; (2) there must be no break in the regular routine by which the desirable habit is being established; (3) the work given to the patient must not be too difficult, since the stimulus of success is necessary to sustain his interest.

The latter part of the article is given up to an account of the practical application of these principles at the Danvers State Hospital. Emphasis is laid upon the necessity for using great care in selecting the instructors for this class of patients—since not every teacher of occupational therapy is qualified to handle them successfully—and for keeping the work purely therapeutic in character; "there should be no thought on the part of the instructors to produce objects that could be sold or even to make a great display." Dr. Bryan does not claim any wonderful recoveries as a result of this experiment in rehabilitation, but he does state that in every case there has been some improvement and that the work has come to occupy a definite place in the hospital's plan of treatment.

A STATISTICAL SYSTEM FOR THE USE OF INSTITUTIONS FOR CRIMINALS AND DELINQUENTS. By Horatio M. Pollock. *Journal of Criminal Law and Criminology,* 11:440-46, November, 1920.

The Committee on Statistics of the American Institute of Criminal Law and Criminology, in this, its yearly report, offers "a plan for the preparation of statistical data in institutions for criminals and juvenile delinquents." The formulation of a standard method of classification of the desired data was the first step necessary. It was decided that from the standpoint both of prison administration and of the welfare of the prisoner, the primary consideration is the prisoner's mental status. The first classification submitted by the committee is therefore as follows:

Mental Classification of Criminals and Delinquents

- I. No demonstrable abnormality.
- II. Mental deficiency:
  1. Imbecile
  2. Moron
  3. Border-line
- III. Mental disease:
  1. Traumatic psychoses
  2. Senile psychoses
  3. Psychoses with cerebral arteriosclerosis
  4. General paralysis
  5. Psychoses with cerebral syphilis
  6. Psychoses with Huntington's chorea
  7. Psychoses with brain tumor
  8. Psychoses with other brain or nervous diseases
  9. Alcoholic psychoses
  10. Psychoses due to drugs and other exogenous toxins
  11. Psychoses with pellagra
  12. Psychoses with other somatic diseases
  13. Manic-depressive psychoses
  14. Involution melancholia
  15. Dementia praecox
  16. Paranoia or paranoid conditions
  17. Epileptic psychoses
  18. Psychoneuroses and neuroses
  19. Psychoses with psychopathic personality
  20. Psychoses with mental deficiency
  21. Undiagnosed psychoses
- IV. Psychopathic personality:
  1. Inadequate
  2. Emotionally unstable
  3. Egocentric
  4. Others (specify)

Scarcely less important than the mental status of the prisoner are his behavior characteristics. These are made the basis of a second classification, as follows:

1. Emotionally unstable behavior
2. Profligate
3. Vagrant
4. Dishonest

5. Eccentric
6. Egocentric
7. Sexually abnormal
8. Others (specify)

A third classification valuable from the standpoint of prison administration is concerned with types of offenders. This includes four groups:

1. First offender
2. Accidental offender
3. Occasional offender
4. Habitual offender

The report includes also recommended forms of statistical data cards for the use of institutions in recording and reporting data concerning admissions, discharges, transfers, and deaths, with suggestions as to their use, and a list of the statistical tables that should appear in every annual or biennial report issued by institution or department.

THE STATE HOSPITAL PHYSICIAN IN RELATION TO CLINICS FOR MENTAL DEFECTIVES. By William C. Sandy, M.D. *The State Hospital Quarterly,* 6:77-81, November, 1920.

This paper, by the psychiatrist of the New York State Commission for Mental Defectives, emphasizes the point that the mental clinic "should not be regarded as a receiving station for the admission of mental defectives to institutions," but that on the contrary commitment to an institution should be a last resort. This attitude is essential, not only in fairness to the patient, but as a matter of expediency, in view of the limited institutional accommodations at present available. The clinic's study of an alleged mental defective, therefore, should include, besides the intelligence test, an examination for such physical defects as malnutrition, enlarged tonsils and adenoids, or defective vision or hearing, which might have resulted in retardation and apparent feeblemindedness. The neuropsychiatric aspect of the case also should not be neglected, since temperamental defects in an intellectually normal individual are sometimes mistaken for mental defect. Even after mental defect has been definitely established, institutional commitment is by no means always indicated. Many mental defectives of school age can be suitably provided for in special classes in the public schools; while for those of sixteen years or over, supervised parole can often be safely recommended, thus giving them a chance to perform useful work in the community and become partially or wholly self-supporting. Commitment to an institution should be reserved for cases most urgently in need of custodial care or of training of a sort that cannot be provided elsewhere, such as cases of "continued delinquency and uncontrollable antisocial behavior, improper guardianship that cannot be corrected, or extremely low-grade mentality."

MORE ADEQUATE PROVISION FOR EPILEPTICS. By William T. Shanahan, M.D. *New York Medical Journal,* 112:879-84, December 4, 1920.

After a brief review of the present inadequate facilities for the care and treatment of epileptics in New York, Dr. Shanahan, Medical Director of Craig Colony, discusses some of the ideals that should be aimed at in establishing a colony for epileptics.

The site should be reasonably near a city or large town and sufficiently adapted to the buildings that are to be erected upon it not to require a great amount of preparation.

The first patients sent there should be capable of working regularly, except in the case of an occasional seizure, and should require little supervision. Patients who are so disabled physically or mentally that they cannot work and require a great deal of care are too heavy a handicap upon the institution in the early days of its existence.

The educational work should include not only the younger patients, but the older patients who were deprived of educational advantages in their younger years. Educational work with epileptics has a distinctly therapeutic value.

Extended classification of the patients—according to age, sex, grade of mentality, etc.—is of supreme importance. This will necessitate a number of small buildings instead of a few large ones.

As to size, a colony with a capacity for from five hundred to a thousand patients is recommended. A smaller colony than this cannot be so economically administered, while in a larger one it is difficult for the superintendent to keep in close personal touch with the patients and the activities of the institution.

The occupations offered the patients should be most varied. Work is a valuable means of treatment in the case of epileptics, often seeming to decrease the number of seizures and prevent mental deterioration. Farm and garden work are the most valuable forms of labor, both from the standpoint of treatment and that of financial return. In providing both occupations and recreations, the therapeutic aim of the institution should always be the first consideration.

A state institution, while it cannot be expected to provide the luxuries of life for its patients, should provide the essentials—

"proper housing, food, clothing, medical and nursing care, sensible hygienic methods as to bathing, recreation and other activities, with all reasonable opportunities for friends and relatives to visit patients, and assignment, so far as means permit, of compatible patients in each cottage."

Each patient should be allowed all the liberty that his condition warrants.

The village idea should always be foremost in the development of a colony, so that the stamp of the institution may be as much in the background as possible.

The salaries and living conditions of employees should be such as to attract desirable types of workers.

Institutions for epileptics should operate under a law providing that all mentally incompetent applicants be committed through a proper court, while applicants of normal mentality are received as voluntary patients, with the understanding that they may leave the institution upon short written notice.

The work of such institutions should include follow-up work and after-care of discharged patients and the dissemination in the community of information and advice concerning epileptics.

BOOK REVIEWS

THE PSYCHOLOGY OF FUNCTIONAL NEUROSES. By H. L. Hollingworth. New York: D. Appleton and Company, 1920. 259 p.

Students of mental phenomena are divided, to-day, into two schools or camps with markedly contrasting viewpoints and methods. They are psychopathologists and what we may term "academic psychologists." The former observe abnormal psychic reactions, endeavor to reconstruct the functions thereby analyzed and thus arrive at some knowledge of the normal, which is too complex to be understood in its complete integration. This is analogous to the method of experimentation which has advanced the science of physiology in the last forty or fifty years. The academic psychologists, on the other hand, first worked by introspection and more recently by measurements of normal function. (A third school, that of the behaviorists, might be mentioned, although their methods and viewpoint are not germane to the present discussion. They examine such primitive reflexlike behavior as is common to man and animals and assume that a complication of the simple mechanisms observed may produce the elaborate mental behavior of the adult man.) The material suitable for both introspection and measurement is limited to the static functions of sensation and intelligence, and the academic psychologists have taught us much that is essential about perception, attention, retention, apprehension, etc., as well as the capacities of the special senses. The psychology of the emotional part of lives, however, of the power of certain ideas, of instincts, of the origin of our feelings, and so on—all this is too elusive for introspection and incapable of measurement, but is capable of analysis in pathological conditions. The two fields of research have no immovable fence between them, but they are essentially different. There should, therefore, be no antagonism between these different groups of workers, yet, with a few brilliant exceptions such as William James, Stanley Hall, and Lyman Wells, the academic psychologists have apparently been jealous of the psychopathologists. They have ignored the latter's material and disputed their claims often with vituperation. Resentment has not been wanting.

Yet there is common ground in which each school can aid the other. This is in the study of the social and individual problems arising out of the abnormalities and subnormality of the intellectual functions. In recent years the psychologists have done invaluable work with the feebleminded by measuring their intelligence and thereby regulating the educational and industrial demands made on these unfortunates. This advance, however, has not been achieved without sacrifice, for this method of research is fraught with danger. The human mind loves the concrete and obvious. Compare the popularity of Charlie Chaplin and Forbes Robertson. In the scientific world—particularly in the present phase of intellectual evolution—there is a love for that which can be measured. The more intricate and baffling a problem, the more firmly do we cling to such aspects of it as are capable of mathematical representation, thereby protecting ourselves from the uncomfortable feeling of ignorance. The method of academic psychology having contributed to the knowledge and treatment of feeblemindedness, there has been a strong tendency for the proponents of this work to claim that their methods will solve all, or many other, human problems. Thanks to the universal satisfaction in the concrete, the uncritical public have been largely impressed with these claims. Hence little outcry arises when statements are made such as that all prostitution or all crime is due to mental defect because some considerable number of wayward women and jail inmates grade low on a Binet scale. Yet a moment's consideration shows that conduct is determined by desire and that what we want is not nearly so much a matter of intelligence as if it is of emotion. To take a glaring example, the man in high office who elopes with another's wife does not do so because he is stupidly unaware of the consequences, but because he wants her more than he cherishes his good name. The defective criminal may be less capable of calculating his sacrifice and his poor intelligence may restrict the field of his desires, but his craving for the unlawful is, of itself, as purely an emotional thing as is the lust of the gifted reprobate. Psychometry—the science of intellectual measurement—can therefore make only indirect contributions to the study of conduct or of the emotions generally.

This tedious introduction has been necessary in order to explain the space given to review of the book before us. Its importance lies not in its absolute worth, but in its being representative of the work of a school whose claims receive more attention than the facts perhaps warrant. The war neuroses presented problems of equal military and medical importance. In the A. E. F. these casualties were treated by psychopathologists who regarded the conditions as purely emotional in origin and achieved brilliant therapeutic (and military) results by working on this basis. A small number of these cases were returned to this country and, relatively speaking, a handful of these were examined by the author. On the basis of his observations he presumes to outline a theory for all psychoneurotic reactions. It should be added that he presents no evidence of prior contact with any psychopathological material and that he has had no medical education.

It is often stated that theories pass through three stages of recognition. First they are ridiculed, secondly an admission is made that there is something in them, and finally the claim is made, "We always said so." Many academic psychologists have passed through the first two stages in regard to psychopathological theory, and Professor Hollingworth has just launched himself into the third. He takes a fundamental concept, common to both the psychology of Freud and Prince, gives it an old name, and denies any value to the work of the psychopathologists. This concept is that symptoms arise as reactions to past experiences of a complex nature, the present stimulus representing only a part of the original experience which is not recalled in its entirety. To quote the author, "Redintegration is to be conceived as that type of process in which a part of a complex stimulus provokes the complete reaction that was previously made to the complex stimulus as a whole . . . A child is frightened by a large, black, growling and moving quadruped. Both stimulus and reaction are complex. On a later occasion the growl alone provokes the entire fright reaction, even when made by a parent crawling on all fours, or hiding behind the door." This term of "redintegration" he takes from Hamilton, who used it for something analogous yet different, namely, "the tendency of a complex idea to be reinstated upon the occurrence of one of its constituent parts." In Hollingworth's "redintegration" only the reaction to the original idea recurs, *not* the idea itself.

The redintegrative response, he says, may take place on any one of three levels. On the normal or "cortical" level, a train of thought is set up by the stimulus which leads to complete memory of the original situation and a reasonable response. On the "spinal" or "postural" level, movements or attitudes of fight, defence, aggression, etc., take place which are appropriate to the original, but not the present stimulus. On the "automatic" level, smooth muscle, visceral and glandular reactions are set up which appear in consciousness as emotional feelings. Uninhibited "spinal" reactions give hysterical symptoms, the "autonomic" such emotional states as appear with pathological anxiety. Successful cortical redintegration inhibits or modifies the other two so that the whole reaction is not abnormal. Fundamental problems of psychiatry are neatly solved and disposed of in the following sentence: " . . . if there is an attempt to rationalize this experience (insistent fear, worry or dread) of the fixated autonomic response, this leads to the pictures of melancholia, paranoia, or the compulsive neurosis, depending on the nature of the emotion and the other characteristics of the individual." Only prolonged thought can give a psychiatrist an idea of the enormity of ignorance displayed in this quotation.

This theory—or rather description of phenomena demonstrated daily—implies the existence of an unconscious idea. If I am frightened by a bull, and later get the same fear reaction when I see a piece of horn lying on the table, although I do not think consciously of the bull, I must have an *unconscious* image of the charging beast in my mind. Hollingworth states plainly that these abnormal reactions do not take place when complete awareness of the memory is present (pp. 74, 75), but only when the subject is unaware of the effective stimulus. If there be memory of an idea, the memory be stimulating some reaction, yet the subject be not conscious of the idea, surely this memory is unconscious. Yet Hollingworth attempts to drown this conclusion in the following verbal cataract: "A special merit of the redintegrative concept is to be found in the ease with which it dispenses with the elaborate fiction of the efficacious unconscious. Therapeutic attempts would presumably proceed with equal success on either hypothesis. The one hypothesis, however, flagrantly and naively ignores the familiar canons of demonstration and proof, while the other seeks to articulate itself in an intelligible fashion with the ordinary psychology of the accessible."

Those whose profession it is to analyze the mental mechanisms of neurotic symptoms find these "redintegrative" phenomena universal and are forced to adopt the working hypothesis of an unconscious mind not merely because the facts imply it, but because it explains the ignorance of the patient as to the cause of his reactions. Forced to substitute something for this hypothesis, if he is to publish anything new, Hollingworth suggests that the ignorance is due to a lack of sagacity, in other words, that the psychoneurosis is related to feeblemindedness. That he means this seriously is shown by the fact that he spent much time in efforts to prove the defect and has written a book about it.

It is, of course, an easy matter to show on the basis of clinical material that the factors entering into psychoneurotic reactions are emotional rather than intellectual, but the demonstration would be tedious and most readers are quite conversant with it. But it may be interesting to examine Professor Hollingworth's work, since evidence of a universal mental defect among psychoneurotics would force us to consider it as at least a contributory factor in the production of neuroses.

His chief findings are epitomized in the following table,[1] which is made up by appending the average mental ages from Table IV to Table III (pp. 87 and 88). The table shows in each clinical group the number of cases who passed the tests for the mental ages recorded in the first column.

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[1] There are several inconsistencies in this table, but it is published as it appears in the book.

	Mental Deficiency	Epilepsy	Hysteria	Constitutional Psychopathy	Neurasthenia	Psychoneurosis	Concussion	Psychasthenia	Cerebro-spinal Meningitis	Organic Conditions	Psychoses	Undiagnosed	Totals
Failed . . .	3	28	15	2	5	9	1	0	0	5	1	18	83
5- 6	2	1	2	0	0	0	0	0	0	0	0	2	7
6- 7	1	4	5	0	0	1	0	0	0	0	0	3	14
7- 8	6	12	10	2	1	8	2	0	0	0	0	9	50
8- 9	13	36	15	5	6	7	1	0	0	2	3	17	105
9-10	5	36	19	5	7	9	3	0	2	3	1	24	114
10-11	9	31	14	7	8	7	7	1	1	4	2	25	116
11-12	0	35	16	6	11	16	6	1	2	7	1	31	133
12-13	1	35	16	5	6	9	3	1	6	7	0	19	108
13-14	0	29	15	2	11	10	4	2	2	4	1	18	98
14-15	0	22	11	3	8	10	3	1	5	4	1	21	89
15-16	0	15	13	1	3	6	3	1	1	1	1	13	58
16-17	0	31	16	5	10	11	6	2	3	6	2	20	112
17-18	0	16	7	5	1	6	2	0	2	5	3	5	52
18-	0	8	3	0	6	5	0	1	2	1	0	7	33
Total . .	40	339	177	48	83	114	41	10	26	45	16	232	1172
Average mental age	9.0	12.0	11.9	12.5	13.0	12.6	13.0	14.9	14.6	14.0			

An examination of these figures shows that only 384 cases were diagnosed as hysteria, neurasthenia, psychoneurosis or psychasthenia. The others were not neuroses at all, yet he not only prefaces his book with the promise of examining some 1,200 neurotics, but in many of his arguments deals with the mental endowment of his total material as of "psychoneurotics."

Let us examine these figures more in detail.

The average mental age of all the psychoneurotics turns out to be 12.4. The average mental age of recruits sent to France was 14.0, so that these psychoneurotics were on the average developed intellectually 1.6 years less than their fellows. Unfortunately for the validity of these figures the author has added material of interest to the special technicians of psychometry, which, though irrelevant to his thesis, gives data of use in criticising his results. The first had to do with "scattering" in the performance of the mental tests, that is, the tendency to perform better in some tests and poorer in others rather than to show an even efficiency on all tests up to a certain age level. Scattering has long been recognized as a characteristic of psychotic rather than of feebleminded patients. It is apparently due to variations in interest, attention, inhibitions, etc., which are incidental to the disease of the patient. Hollingworth found that his material showed a marked tendency to scattering, particularly in the hysteric group. Now it is theoretically impossible for any one to exceed his native intellectual capacity; hence all deviations must be the result of indifference or inhibition that tends to rate lower than his actual intellectual endowment would justify. Consequently we are justified in adding the difference between the average deviation of the psychoneurotics and the average deviation of the feebleminded to the average age determined for the psychoneurotics in each group. For instance, the average deviation of the hysterics was 2.0 years and of the feebleminded 0.9 years. The difference of 1.1 years added to the average mental age of the hysterics brings it up to 13 years. Similarly the neurasthenics reach 13.7 and the psychoneuroses 13.3.

A second defect in his method which the author unwittingly exposes has to do with the type of tests employed. All of the cases were examined by "group surveys" where the intelligence ratings of newly arrived patients were made in batches. Only in some 93 instances were these controlled by individual examinations. In order to test the reliability of these group surveys the results in the 93 cases were compared with the findings of the initial examinations of the same patients. An average difference of 1.3 years was discovered, which usually ranked the patient higher in the individual than in the group test. Of course since the examination of recruits was made by the group-survey method, this difference would tend to indicate a somewhat higher standard than 14.0 years, just as it would elevate the ratings of the psychoneurotics. But as the latter are more apt to need individual encouragement to put forth their best efforts, it is safe to assume that individual tests on these 384 cases would have rated them relatively higher than they are represented.

Taking these two factors into account, we are probably right in believing that in the most defective of Hollingworth's patients (the hysterics) the actual defect demonstrated is, on the basis of his tests, less than one year's development behind the average of the army. Nevertheless this is something and he has also shown a relative inferiority of the hysterics as compared to the other groups. How can the slight defect be accounted for? Those who were in the Neuropsychiatric Service in France know the answer well. Up to the time of the armistice only those psychoneurotic cases who showed severe symptoms in spite of careful and expert treatment were evacuated to the United States. They were mainly cases who had been abnormal prior to enlistment, but had escaped the scrutiny of the draft boards. From the beginning of the St. Mihiel offensive to the armistice they were only 1 per cent of all the neuroses arising in battle. During the same period 11 per cent of the cases recovered sufficiently to be returned to duty behind the lines as B and C class men. It was not until well towards the end of 1918 that these B and C class patients began to be evacuated to America. Since it took a full month on the average for a soldier to reach Plattsburg after leaving France, it is impossible that Professor Hollingworth saw much more than the 1 per cent before his work finished at the end of January, 1919. These were the dregs, as it were, of the neuroses. They were the rank failures. Now if one examines 100 failures in any jail, poorhouse or asylum and also 100 men picked at random from the community at large, he will find that the former are inferior to the latter. This inferiority will show itself in a high rate of deformities, "stigmata of degeneration," feeblemindedness, emotional instability and personality defects. Not one of these things is specific, but the statistics will be imposing. Another observer could probably have taken Hollingworth's material and shown with equal force that the war neuroses were due to adherent lobules of the ear, high palates, asymmetric faces, misshapen heads, and so on. There were some 11,000 neuroses in France that developed under highly unusual circumstances. The author saw 384 cases culled so as to eliminate the typical ones. He examined these in wholesale lots, retired with his examination papers and writes the *Psychology of Functional Neuroses.*

Before leaving the subject of the alleged intellectual defect of these cases, a word should be said as to the value of statistical studies in material of this sort and as to the reliability of his tests. If 75 out of 100 men should admit that they no longer loved their wives, could any one then claim that the average American is one-quarter in love with his wife? In problems of this order essential factors must be present in every case or they are not essential. If 99 out of 100 hysterics were demonstrably feebleminded, the presence of normal intellectual capacity in the one-hundredth would show that the defect was not essential, but only a contributory factor or a coincidence. From his own tables it appears that some hysterics were above the mentality of the average soldier. From the fact that the psychasthenics were above the average (and that those with subjective and emotional symptoms were generally of superior intelligence) he argues that this neurosis affects those of superior intelligence *in virtue of that intelligence,* speculating much as to how this comes about. From the table above one sees that 2.6 times as many cases of cerebro-spinal meningitis were also more gifted than the average soldier. Did intelligence also produce meningitis?

The book is full of such pointless statistics, in fact the author admits in some cases that the significance of them is not clear. One chapter is devoted entirely to tables showing the geographic origin of his patients, their trades, etc., all of which are as instructive as data would be which they might supply as to their clothes in civilian life.

Then as to his tests. Hollingworth is much interested in the fact that the psychoneurotic cases tended to group themselves around the age levels of the eleventh and sixteenth years. These "modes" show, he thinks, that both superior and inferior intelligence tend to produce or perpetuate neuroses. To the reviewer a simpler explanation seems probable. All his groups, including organic nervous diseases and meningitis, showed this bimodality. If the organic cases show it, normal people will too, and, if that be the case, the tests are not properly standardized.

In his zeal to make out a case the author has scanned the literature to find confirmation of his claims. One author speaks of 90 per cent of cases showing a constitutional predisposition, mainly of the schizophrenic and defective group. Another says frankly that the majority of the patients are below the average of mentality as measured by the Binet-Simon scale. Otherwise he has no support. But he endeavors to twist innumerable reports of *relative and general inferiority* of hysteric to anxiety patients into the statement of absolute intellectual defect. When these authors speak of the development of hysteric conversion symptoms being favored by ignorance of physiology, he asserts that their poor education is the result of feeblemindedness. If that be the case, there must be infinitely more feeblemindedness in Europe than America, for civilian hospitals receive many hysterics in England and the Continent, while they are quite rare in this country. Jingoes would enjoy this conclusion more than statisticians. That ignorance is not feeblemindedness is shown by Professor Hollingworth himself, who consistently writes of concussion as a psychoneurosis.

The style of the book is generally readable, if a little difficult at times, the obscurity being increased by the use of esoteric technical terms. Apparently the work is intended for eyes of laymen, yet we find such a sentence as this: "The semi-interquartile range of both medians is 2.5 years." None of these terms is anywhere defined. Ignorance of common psychiatric facts, even of the meaning of simple diagnostic terms, appears every few pages.

That scientifically this work is valueless is clear; that, if read uncritically, it may be pernicious is probable. But does the mischief end there? Our soldiers are sent to hospitals, like our civilian patients, to be treated, not to be investigated in the interest of preposterous hypotheses enumerated by ignorant laymen. Proper reëducation, says our author, "is possible only after a careful psychological inventory of the patient's capacities and disabilities." In the A. E. F., without the benefit of such technique, 99 per cent of cases were returned to duty and 88 per cent to combatant duty. What is the effect of "psychological" examination and treatment on the neurotic? One would suspect them to be irritating. At least we have this picture of what Professor Hollingworth considers the normal atmosphere of a hospital for neurotic soldiers to be:

"As a result of these various factors, in a military hospital, where detentions are not voluntary, and especially in a hospital for functional conditions as distinguished from the psychoses or insanities, a recognizable atmosphere develops, which combines with the original mental makeup of the incoming or resident patient to produce an attitude of indifference or of overt hostility. There is an indefiniteness of personal aim and endeavor and a general resistance to diagnosis, treatment and rehabilitation."

In contrast to this let us consider the following: In the early years of the war the British government discharged with pensions many neurotic soldiers as incurable. Later some of these were sent by the Ministry of Pensions to a special hospital manned by psychopathologists. Of these chronic patients, faced with a loss of or reduction of their pensions on recovery, 90 per cent were well enough to seek employment in six weeks. In the spring of 1918 abolition of the hospital was threatened. Unknown to the staff the patients sent a petition to the government, unanimously signed, praying that their treatment might be continued and the institution preserved for their own good and that of their fellow sufferers. Does "psychological" investigation produce this attitude?

JOHN T. MACCURDY.

New York City.

THE TECHNIQUE OF PSYCHOANALYSIS. By Smith Ely Jelliffe, M.D. New York and Washington: Nervous and Mental Disease Publishing Company (Series No. 26), 1918. 160 p.

This is the first book that has appeared on the technique of psychoanalysis. In seven chapters the author discusses briefly the material to be analyzed, the literature, sources, and history of psychoanalysis, the opening, general situations, and preliminary formulations of the analysis, the Œdipus hypothesis, transference and resistance, overcoming of the conflicts, socialization of the personality, and use of the dream.

The author tells us that he writes for the neophyte, but many others have read and will read this book on account of the wealth and extent of its intellectual interests. One follows captivated the luxuriant phraseology and abundance of inspiring quotation. The book is difficult to review, however, on account of its discursiveness and circumstantiality. It is hard to convey to the reader the many flashes of light which the author throws upon the incidentals of analysis, for they flash up here and there, not always with direct relevance upon the subject of discussion.

His description of analysis is good: "Psychoanalysis is primarily to be considered as a method. As such it seeks to establish a knowledge of the development of individual human motives. Just as a chemical analysis serves to determine the ultimate composition of this or that substance present in nature, so psychoanalysis has for its task the unraveling of the ultimate composition of this or that manifestation of human conduct. Psychoanalysis, then, is merely a tool, just as chemical analysis is a tool—both are methodological disciplines working with different facts of nature, each seeking to determine ultimates in their respective spheres; the former dealing with data of that portion of the nervous system functioning to adapt the individual and the race to reality, the latter working with the inorganic and organic substances making up a large portion of that reality."

Every one who has had experience with the futile methods of the older schools will be pleased with the exact and brief summary of their lack of results: "For many years official psychology was limited to the so-called physiological psychology. This was practically little more than a detailed physiology of the sense organs. Its study developed a mass of information relative to the receptors and the conducting mechanisms of the special sense organs, facts of great importance, but of little practicability in getting at explanations for human conduct.

"Another important attitude of psychology was its insistence upon what it was pleased to call its 'norms.' The famous dictum that the abnormal in mental life could only be understood from a study of the normal has been one of the chief obstacles to progress. Such an attitude of mind could only have come from the laboratory worker unacquainted with the progress made in the chief biological sciences. For here the great advances in knowledge have come from the pathological side. The normal has been built out of the pathological. Hence when Freud, rejecting all of the dicta of the official and reigning schools of thought, constructed his psychoanalytic method upon pathological data, he followed the path of experience in the other biological sciences, and by avoiding the sterile psychology of that fatuous nonenity 'the normal mind,' founded a method of great value. . . . I think I may say that practically every philosophical hypothesis, save pragmatism, has neglected what are called pathological data, overlooking the fact that pathological does not mean of a different qualitative nature, but simply a variant which must be measured by the same standards as that which is called normal."

The following cannot be emphasized too much: "It is highly advisable for the analyst to point out that his treatment is exclusively medical, and that it is not metaphysical or mental healing, nor anything of that ilk. It is medical sense applied to particular types of problems." The author thus agrees with Freud and his pupils that medical psychoanalysis is primarily a part of psychiatry, and one regrets that he does not adhere to this view in actual practice.

The author adopts the conception of three levels of human reaction —the bio-chemical or vegatative; the sensori-motor reflex or physiological; and the psychical or symbolic, representing reactions of the individual as a whole to the environment. For purposes of psychoanalysis, he divides the patient's life into three periods of growth: "From conception to birth; from birth to five years of age; and from five years of age to adulthood; each of these represents a wonderfully elaborate scheme of reliving the past through a masterful *recapitulation.*"

In the last chapter, his diagrams, schematically representing fixations of libido, unconscious trends as shown in the dream wish, and gradual transformation of the primitive wish as it passes to conscious expression in the dream, are very acceptable; for they bear witness to the way one tends to image personal energy processes after much working with analyses. These diagrams represent developmental levels as well as different areas of libido distribution. Dr. Jelliffe calls the processes, proceeding in order from below upward, the archaic, the auto-erotic, the narcissistic, and the social.

His diagram on page 40 aims to show the first steps in libido distribution following birth and divides the sensory areas into respiratory, nutritive, skin structures, pelvic, and special senses. This scheme allows a more extensive system of terms for discussing the patient's symptoms; but when the author states that "each and every libido area here represented is a compound which analysis endeavors to resolve," the reviewer is thrown into a quandary, for naturally an analysis would take him back to more fundamental libido values. If, however, he endeavors to follow the differentiation and devolopment of these libido values forward into the patient's present condition, he is either following a preconceived theory of racial development and not the patient's individual psychic history, or he has already analyzed the patient's present into these compounds." In neither case is analysis resolving the compound.

One must read the book to appreciate the original and stimulating viewpoint of the author. His technique is his own and does not pretend to be Freudian. He says, "The present series of articles is planned for the beginner in psychoanalysis. They therefore will contain little which the trained analyst does not already know." But in fact they contain much more than he knows, and any one seeking information about technique is more impressed with the fascinating qualities of the author's mind than with what he finds to aid him. A great many of his explanations are confusing to the neophyte, and even the Freudian initiate must stretch them considerably in order to make his meanings clear. This is due to the fact that this technique which does not pretend to be Freudian is nevertheless constantly working with Freudian mechanisms. The experienced analyst must often try hard to forget Freud in order to follow the author.

Although understanding the limitation of definition in dynamic work, the author seeks to give a very exclusive definition of *sexual:* "In this present volume . . . *sexual* means any human contact actual or symbolic by means of any sensory area with the object of the same or of the opposite sex which has *productive creation* for its *purpose,* be it concretely in the form of a child or symbolically as an invention, artistic production, or other type of mutually creative product. It does not apply to those contacts which have purely nutritive or self-preservation instinct behind them. And it does not apply solely to genital contacts." This certainly helps us to make a distinction between intentionally productive and other forms of sexual relation, and consequently suggests a basis for determining conscious social values with regard to sex. It starts a stream of questions, however, about where one should catalogue various other forms of sex activity; and it renders the situation less clear, to make these rigid distinctions, than to allow the word its alimentary and genito-urinary inclusions, as does Freud. It is much less confusing to think of the whole libido as having evolved from polymorphically partial trends and to make the sexual the central dynamic according to Freud: this sexual, as far as genital demonstrations are involved, becoming at times extremely attenuated almost to the vanishing point and transforming into other expressions of creative energy; and at other times becoming obviously related to what we ordinarily call sex. Even the desire for self-protection or for money or for power is an urge toward expressing the life energy. Whether or not this energy is blocked in self-love as distingushed from object-love depends upon much which Dr. Jelliffe does not attempt to discuss.

In the chapter on *Transference and Its Dynamics,* we are introduced to much interesting psychological literature on various subjects.

Occasionally we get flashes of the author's originality: "The physician is a projected wish of the individual's own unconscious. The physican becomes the agent whereby individual immortality may possibly be accomplished. Medicine in its broadest bearings is the projected wish of the community to insure its continuance."

Another keen and interesting idea must be quoted: "It must be borne in mind by any one who is working with psychic material that fundamentally people are much alike; the unconscious, containing a racial recapitulation (inheritance) of one hundred million years, is very much on a par all around.

"I frequently illustrate this to my patients by saying that the entire active life of the indivdual may be represented by a fraction, the numerator of which is any particular moment, the denominator is the rich inheritance of the past. Psychology and most reasoning has heretofore concentrated its attention on the numerator, and has made it appear to be the active life. Conscious knowledge has been made this, the criterion of man's entire activity. The denominator, which is infinitely more extensive and more important, is either neglected entirely or vaguely spoken of as intuition, instinct, temperament, personality. . . ."

If the chapter on *Transference and Resistance* has a fault as a whole, it is that the tenderfoot in analysis for whom the book is written is led to pay too much attention and become too conscious of his own sex, not in Dr. Jelliffe's, but in the layman's sense, and thus he interferes with the psychoanalytic work of liberating the patient from conflicts. It evinces a sex sensitiveness.

This book of 160 pages (not including a preface of two and an introduction of six) contains a great number of abstracts and direct quotations from psychoanalytic authorities, principally Freud, Rank, Ferenczi, Abraham, Reik, Silberer, Maeder, Jones, and it is often hard to tell whether the author is speaking of his own interpretations or of those of others. The quotations from Freud (p. 94) are really no quotations in the exact sense of the word. The author constructed new paragraphs out of passages taken here and there from Freud's very serious paper, and thus often produced "paragraphs" which at best are clumsy and do not exactly reproduce the original.

The chief motive for writing the volume is summed up by the author himself: "I have tried to show the value of a participation on the part of the physician and patient in the greater cosmic view both of the origin and development of that unconscious which must be investigated, as well as its potentiality for the future of the race. There is necessary likewise the detailed appreciation of the individual effort to realize his position in society, his failure or success in handling the forces within him, and the guiding of his libido trends into a successful adaptive relation to cosmic progress.'' And the purpose has been accomplished.

The book is very illuminating and interesting for those who are well acquainted with psychoanalysis. As a technique for beginners its value is questionable.

A. A. BRILL.

New York City.

TABOO AND GENETICS. By M. M. Knight, Iva L. Peters, and Phyllis Blanchard. New York: Moffat, Yard and Company, 1920. 301 p.

The study of the foundation of the family is approached from three directions by three separate authors. *The New Biology and the Sex Problem in Society* is written by M. M. Knight, *The Institutionalized Sex Taboo,* by Iva L. Peters, and *The Sex Problem in the Light of Modern Psychology,* by Phyllis Blanchard.

The first part, dealing with the biology of sex, is well done and contains a great deal of information of interest and importance in approaching the larger social problem. There is an interesting discussion of the nature of sex and its basis in the sex chromosomes. The work of Dr. Lillie on the Free-Martin and Bell's work on the Sex Complex are interestingly reviewed in relation to the question of intersexes and the masculine and feminine components of character. Ward's ''gynaecocentric'' theory is discredited.

In the second part the whole question of sex is taken up with reference to taboos and in it is shown how sex taboos, which have survived their usefulness, continue to dominate beliefs, customs, and institutions. There is a very interesting discussion of the ambivalent attitude toward woman as saint and witch.

The third part discusses the directions in which development of ideas and practice regarding sex seems to be tending, and is in general a plea for an extension of the field of conscious control, and a replacement by control of prejudice and taboo. There is an excellent discussion of the needs of the individual versus the needs of the community, and a very suggestive interpretation of some of the present difficulties as based upon an arbitrary standard of masculinity and femininity. The author feels that it is essential for the welfare of the race that social premiums and standards should be so changed as to make it to the advantage of the superior stocks to reproduce.

WILLIAM A. WHITE.

St. Elizabeths Hospital,

THE NEW PSYCHOLOGY AND ITS RELATION TO LIFE. By A. G. Tansley. New York: Dodd, Mead and Company, 1920. 283 p.

This book contains thirteen chapters in which the author aims to present in a comparatively short space, and without employing more than the most essential technical terms, a fairly comprehensive sketch of the vital characters and activities of the mind. The book is divided into six parts: an introduction dealing with the new psychology, and the physical and psychical worlds; the structure of the mind; the energy of the mind; byways of the libido; reason and rationalization; and the contents of the mind.

The book has fairly fulfilled the purpose for which it was written. But the exposition of the new psychology is not really clear, and can be comprehended only by those who know their way about in the subject. No one school of thought has been followed exclusively, so that gaps and inconsistencies appear in the presentation of the subject as a whole. The author's application of the new psychology in its relation to life is very disappointing in that he brings out nothing essentially new nor is his application especially convincing.

One great fault in books of this type is the absence of apt clinical illustrations. Secondly, they should be written by medically trained minds—an absolute necessity if we are to get anywhere in a special field of medical science in which there is so much difference of opinion and method of approach. So far as a thorough exposition of the essential nature of the new psychology is concerned, with clearness of presentation, Freud's most recent work leaves nothing wanting. The application of such principles to problems of life could hardly be better presented than by White in his various writings which are those of a well seasoned psychiatrist. Even in the preface the author's use of such terms as "madman" and "lunatic" shows the possible gain of rhetorical effect at the expense of a more humane or scientific use of terms. No psychiatrist would strive for such an effect at the expense of the gentler minded.

Finally, one may say that the whole subject is so involved that even the trained worker can hardly discover the fundamental conception of the author by his use of the term "primary unconscious" as being quite distinct from the "Freudian unconscious." Had the author been able to devote his entire book to the latter object of his study, he might have been able more fully to expound that phase of his subject. But have we sufficient data as yet, beyond the purely personal uses of the new psychology, to formulate very exact and full applications of these principles to the broader and general uses of society?

L. PIERCE CLARK.

New York City.

THE GROUP MIND. By William McDougall, F.R.S. New York: G. P. Putnam's Sons, 1920. 418 p.

Sociologists may have found the author's *Introduction to Social Psychology,* which was published in 1908, unsatisfactory because of its too exclusive preoccupation with psychology, but to the student of human nature that truly noteworthy and original contribution has been an inexhaustible source of inspiration and guidance. It is therefore doubly disappointing to find the author's latest book, *The Group Mind,* so wholly devoid of any reference to the very worth-while contributions to the study of human nature in its individual and collective manifestations that have come to light since 1908.

If one were to insist that no worth-while book on the group mind could be written without reference to the contributions of Freud, Trotter, Graham Wallas, and others who have concerned themselves with the dynamics of collective thought and action, it does not necessarily mean that one is wholly in accord with these writers. Whatever one's attitude may be to the Freudian psychology, the conviction is no less genuine that such concepts as those of the unconscious, the censor, repression and projection, the wish element in human action, and Trotter's treatment of the herd instinct cannot be ignored in any discussion of collective psychology.

Neither can one ignore in a work of this kind the concept of "balked disposition" which economists have found to be fruitful in explaining some of the outstanding phenomena of group psychology. McDougall, however, seems to have taken special pains to avoid any of these concepts in his discussion of the group mind. If this omission was prompted by a desire to avoid distraction from the author's main thesis, it has, we fear, not resulted in the kind of clarity of presentation that would leave the reader with some sort of clear-cut conception of the group mind. The essential theme of the book, as set forth by the author, is: "The resolution of the paradox that while participation in group life degrades the individual, assimilating his mental processes to those of the crowd, whose brutality, inconsistency, and unreasoning impulsiveness have been the theme of many writers, it is only by participation in group life that man does become fully man. Only so does he arise above the level of the savage." The book, in the author's words, examines and fully recognizes the mental and moral defects of the crowd and its degrading effects upon all those who are caught up in it and carried away by the contagion of its reckless spirit. It then goes on to show how organization of the group may and generally does in a measure counteract these degrading tendencies and how the better kinds of organization render group life the great ennobling influence by the aid of which alone man rises a little above the animal and may even aspire to fellowship with the angels. So much for the aims of the book.

How well they have been achieved the reader must judge for himself. To the reviewer, Mr.Dougall's rather forced differentiation between "collective consciousness" and his "group mind," with the provisional rejection of the former and unqualified acceptance of the latter, is quite illustrative of the type of difficulty that is encountered in the book and that is bound to lead to considerable confusion. A reading of *The Group Mind* strengthens the conviction that a satisfactory sequel to the author's *Introduction to Social Psychology* is yet to be written and that in all probability this will have to be done by some one who is in greater sympathy with modern psychological tendencies than is McDougall.

BERNARD GLUECK.

New York School of Social Work.

THE NERVOUS HOUSEWIFE. By Abraham Myerson, M.D. Boston: Little, Brown and Company, 1920. 273 p.

Those who are wholly in accord with Freud's doctrine of the neuroses will naturally find themselves out of sympathy with the author's treatment of this subject, but it is doubtful whether on this account even the most confirmed Freudian will fail to recognize the real and abiding merit of this book. The author has put into clear and simple language the ordinary, everyday manifestations of nervousness in the housewife of our day and time, and in his lucid discussion of causation has escaped the widespread fallacy of seeking for something profound and complex. On the contrary, due weight is given here to the commonplace events and conditions of American life which create the setting in which nervousness thrives, and the error is made obvious of neglecting to take into account, in the treatment of these individuals, these determining environmental factors.

Physicians, especially those who are busily preoccupied with mental pathology, will do well to heed carefully the author's reference to the social-pathologic issues involved in psychiatry, since the troubles of our patients reflect so largely disturbances in their external economy.

The author has clearly grasped the significance in human life of the "urge to put oneself across" and sees with great clarity the nervous reactions called forth by a balking of this urge. Thus the nervousness of the housewife becomes an occupation neurosis and its prevention will depend upon our capacity to devise means that will make it possible for the average housewife to achieve, in spite of the oppressive monotony of her daily task, an increasing feeling of worth and dignity as an individual. The book is written very entertainingly and with a charm rarely met with in medical treatises.

BERNARD GLUECK.

New York School of Social Work.

WAR NEUROSES AND SHELL SHOCK. By Frederick W. Mott, M.D. London: Oxford University Press, 1919. 348 p.

Possibly to many readers books about "what the war taught us" have become uninteresting and tiresome; but while this may be true of books in general on the problems of the war, scientific books are in a group by themselves, because they have to do primarily with scientific investigation and progress, rather than with military topics. What Mott has written is of particular interest, not solely because of his standing as a scientific authority, but also because of the unusual opportunities that he had for scientific study.

The book does not, as the title would indicate, deal solely with war neuroses and "shell shock," in the sense in which such terms are generally accepted in this country; it deals also with concussion, carbon-monoxide poisoning as related to the nervous system, the effects of irritant gases upon the brain, and other organic conditions of the nervous system.

The text is not for those who have no knowledge of the functional neuroses or of the organic nervous system. Often cases are described without any interpretation being offered. Mott presents these clinical pictures and case histories without any effort to substantiate an organic or psychogenic theory, but merely with the idea of describing conditions as he saw them. Indeed, one feels that Mott himself has no confirmed theories as to when certain symptoms are to be regarded as of organic origin and when of psychogenic. Some cases, as presented, seem contradictory, or at least seem to have both functional and organic features. This method of presentation, however, does not detract from the value of a book, although it would confuse one who has had no knowledge of, or experience with, the war neuroses.

The first part has to do with histological changes found in concussion cases, causations of different kinds of shock, and the supposed effect of "windage," and these pathological descriptions are illustrated by excellent plates and figures in the text.

The latter part of the book has to do with psychological and pathological functioning, hysterical states, paralysis, contractures, malingering, psychoses, alcoholism, etc. and various forms of treatment are considered.

The interest and value of this book rests on more than scientific considerations. It is dedicated as follows: "To a Group of American Medical Officers Who Worked With Me at the Maudsley Hospital this little book is dedicated as a friendly mark of appreciation of their earnestness and efficiency in the study and treatment of cases of war neuroses admitted under my care."

These officers gained in ways other than scientific by their association with Mott. Besides an intimate personal relationship, which they will never forget, they became interested in English ways of thinking of psycho-pathological matters; such men as Mott, Rivers, and McDougall, to mention but three, present subjects from a point of view somewhat different from our own. Again, the English medical officers must have gained likewise in their association with the dozen or so American medical officers from the neuropsychiatric service of the United States Army. If an interchange of ideas of this kind could happen more frequently, and did not have to depend upon such a catastrophy as war to bring it about, medical science would undoubtedly gain by it.

SANGER BROWN, II.

New York City.

THE MEDIÆVAL MIND; A HISTORY OF THE DEVELOPMENT OF THOUGHT AND EMOTION IN THE MIDDLE AGES. By Henry Osborn Taylor. New York: The Macmillan Company, 1919. Vol. I, 603 pages; Vol. II, 621 pages.

The title of these two volumes, of over 1200 pages in all, may be somewhat misleading to its readers, as it was to the reviewer. The book does not exactly discuss the qualities of the mind of man of the mediæval period, but there are contained in it historical facts, accounts of religious fanatics, and political and social records, which enable one to appreciate to a considerable extent the meaning of some of the peculiar trends of thought of that period—trends similar to those seen today in psychopathic people.

Of a period in the mental development of the race earlier than the mediæval, we have access to some interesting observations. Ethnologists particularly have collected such data—Rivers on the Todas, Hewitt and Spencer on the primitive Australians, Boas on the aborigines of this country, and such men as Tyler, Frazer, Gilbert Murray, and Andrew Lang, to mention but a few. These writings give us a considerable degree of insight into the mind of so-called primitive man. Of the mediæval period, we have no observations of this particular kind. Taylor's book does not furnish us with them, but he does furnish us with a great deal of interesting data about this semicivilized period—semicivilized, at least, in many respects.

These volumes are too scholarly and too full of details and quotations of various kinds to be dealt with properly in a review. The reader will find presented many interesting facts about the religious, social, political, and military life of these early centuries. As a rule, these descriptions are impersonal, and they have to do with institutions; when they have to do with individuals, as is occasionally the case, they are most illuminating.

Take, for example, Romuald the Hermit's fight against evil. "The devil would come striking on his cell, just as Romuald was falling asleep, and then no sleep for him. Every night for nearly five years the devil lay on his feet and legs, and weighed them down with the likeness of a phantom weight, so that Romuald could scarcely turn on his couch. How often did the devil let loose the raging beasts of the vices! And how often did Romuald put them to flight by his dire threats! Hence if any of the brethern came in the silence, knocking at his door, the soldier of Christ, always ready for battle, taking him for the devil, would threaten and cry out: 'What now, wretch! What is there for thee in the hermitage, outcast of heaven? Back, inclean dog! Vanish, old snake!' He declared that with such words as these he gave battle to malignant spirits; and with the arms of faith would go out and meet the challenge of the foe."

While conduct of this kind, extending over a period of five years and doubtless much longer, is scarcely to be regarded as indicating a psychosis, similar actions at the present time would arouse grave doubts of a man's mental equilibrium. The whole condition has to be considered in its setting and interpreted as a part of the spirit of the times.

Again, take this case of an ascetic woman, this time described by Jacques de Vitry:

"I saw another who sometimes was seized with ecstacy five-and-twenty times a day, in which state she was motionless, and on returning to herself, was so enraptured that she could not keep from displaying her inner joy with movements of the body, like David leaping before the Ark. And I saw still another who, after she had lain for some time dead, before burial was permitted by the Lord to return to the flesh, that she might on earth do purgatorial penance; and long was she thus afflicted of the Lord, sometimes rolling herself in the fire, and in the winter standing in frozen water."

Conditions of this kind, probably not understood in their psychological significance by the author of the book, are of assistance in interpreting similar states that we see to-day in psychopathic people. For this reason the volumes are of value to the psychiatrist. The text is replete with quotations and references, whose full meaning may not be understood by the ordinary reader—were not, at least, by the reviewer—but there is also much psychopathological material in the text that will be understood only by those familiar with psychological mechanisms.

SANGER BROWN, II.

New York City.

FATIGUE STUDY. By Frank B. Gilbreth and Lillian M. Gilbreth. New York: The Macmillan Company, 1919. 175 p.

The central thesis of this excellent little book is that there is a huge loss to the nation—and the world—in preventable fatigue. "Fatigue study has principally to do with that part of the science of work that is most necessary for producing large outputs." The book deals with the fatigue problem in industrial plants, and the study itself is based on the measurement of movement.

The authors discuss both the sources of fatigue and the remedies. The sources of fatigue, for the Gilbreths, lie in bad worktables, poorly built chairs, wrong types of clothing; poor lighting, heating, and ventilation of the workshop; insufficient rest hours and overlong hours of work, etc. In other words, the physical basis of fatigue is studied, and remedies are suggested in what is obviously efficient—good tables, proper chairs, efficient lighting, rest hours—and the like. Incidentally the authors recognize some form of happiness as the aim of life and urge elimination of fatigue not only because fatigue hampers production, but because it hampers happiness.

This plainly written book is a worth-while investment for everybody interested in industry, social welfare, and mental hygiene. The reviewer wishes, however, that some one would deal with the fatigue that arises from blocked purposes, hopeless outlook, thwarted instinct, deviated character—in other words, with the psychological factors in fatigue. Incidently, industry is becoming more and more based on that greatest of fatigue-producing factors—*monotony of occupation.*

A. MYERSON.

Tufts Medical College.

MANUAL OF PSYCHIATRY. Edited by Aaron J. Rosanoff, M.D. New York: John Wiley and Sons, Inc., 1920. 684 p.

This is a very readable book and one worth any one's permanent ownership. It has some chapters not usually found in textbooks of psychiatry, and notably the too short chapter on the social aspects of psychiatry. Dr. Rosanoff shows his progressive spirit in thus recognizing that psychiatry, like the rest of medicine, must officially add the social worker to its armamentarium. Also, the lessons of the war have been utilized, and thus the volume is modernized in a commendable manner.

There are some glaring defects in the book which the reviewer points out in the friendliest spirit. Chief amongst these is the disproportionate handling of the various topics. Psychiatry should recognize that the psychoneuroses are the most common of the mental diseases and give them more than the twenty-seven pages that this volume allots. Neurasthenia, which is here barely mentioned, is a mental condition, and is perhaps the most common of all diseases.

One may grant an author the privilege of considering psychoanalysis of the Freudian type at some length and neglecting all other forms of psychotherapy, except for four pages of extract from a layman's book. But how reconcile the seventy pages given to free association tests and the fact that pellagra is merely mentioned? By space allotment, the editor of the book evidently considers these tests as important as dementia praecox, manic-depressive psychoses, and the psychoneuroses combined. And while we are willing to see the revisions of Binet-Simon given eleven pages, we cannot reconcile ourselves to the six pages given to the senile psychoses or the ten pages given to feeblemindedness and the associated problems.

The chapters on syphilis are excellent and one can unreservedly commend the excellent analysis made of the phenomena of psychiatry as related to age, marital condition, heredity, etc.

A. MYERSON.

Tufts Medical College.

NURSING IN MENTAL DISEASES. By Harriet Bailey, R.N. New York: The Macmillan Company, 1920. 168 p.

This book marks a definite step forward toward the more general recognition of mental nursing as an art founded on science. It is apparently the first textbook on the care of the mentally sick written by a nurse for nurses. With the increasing attention now being given to mental disease, its prevention, treatment, and cure, it is essential that nurses should have a textbook that gives in lucid style and logical sequence the underlying science as well as the developed technique of treatment.

In her opening chapter, entitled *Psychological Introduction,* Miss Bailey describes mental mechanisms in simple language and dwells on habit domination and the possiblities of re-formation. This chapter might well be studied at the beginning of every course in general nursing. A brief, but arresting, chapter follows on the history of the treatment of the mentally sick both in Europe and America.

A strikng innovation in such a textbook is the chapter on *Prevention*. This bears witness to the hopeful modern attitude towards the burden of mental disease, and from the beginning properly gives the student a look through the windows of the institution into the great field of opportunity outside. The remarks on qualifications for mental nursing emphasize the modern recognition of the fact that the most successful work with mental patients demands the highest intellectual and spiritual gifts. The day of custodial care by kindly, but ill-educated and untrained, attendants is passing. The time has come when education and skilled nurses will make a contribution to better methods of care and treatment of mental cases, such as has been conspicuous in the field of medicine and surgery.

Chapters on symptoms, nursing measures, accidents and emergencies, occupation therapy, and hydrotherpathy are written from the standpoint of a teacher who knows every detail from a practical experience illuminated by an alert intelligence. Psychotherapy and psychoanalysis are briefly discussed, and the significant statement is made that the physician's efforts may be nullified by a nurse who does not understand the principles of treatment. The possibilities and limitations of treatment of the mentally deficient are outlined, and the revised edition of the Binet-Simon tests for intelligence is included in the section on mental defect.

The book contains so much information desirable for every nurse that it should be welcomed in every school of nursing. Instruction in psychiatry will soon be included in every first-class course of training, and Miss Bailey's book will prove a practical guide to the highest standard of mental nursing.

V. M. MACDONALD, R.N.

The National Committee for Mental Hygiene.

THE PSYCHOLOGY OF NATIONALITY AND INTERNATIONALISM. By W. B. Pillsbury. New York: D. Appleton and Company, 1919. 314 p.

Professor Pillsbury gives us a psychological analysis of national group-experience. He attempts to compromise between McDougall's emphasis upon the instincts as a basis for social life and Trotter's interpretation of gregarious fear and social control by convention. Nationality is treated as a psychological product built by experience upon the common social instincts and expressed by the ideals of the nation-group. The League of Nations is merely a new type of group-consciousness, and there is nothing belonging to the human instincts that forbids the successful working-out of super-nationalism. Some of the chapter titles of the book are: *The Nation as a Psychological Unit—Social Instincts, Hate as a Social Force, The Nation as Ideal, Nationality and Super-nationality as Expressed in a League of Nations.*

The author glides easily over the difficulties that stand in the way of any international organization such as the League of Nations. For example, he does not appreciate the significance of early childhood experience in localizing and limiting social sympathy. The book carries the atmosphere of a hurried production, and there is textual evidence that it matured quickly.

The book is a demonstration that social psychology cannot make much headway with practical political problems until it can come to a more reasonable agreement with reference to the number of characteristics of human instincts. At present anything needful for political or social theory is drawn by the psychologist from man's equipment of instincts with the ease with which jugglers in our childhood brought forth the "plug hat" rabbits and other marvels.

ERNEST R. GROVES.

Boston University.

TOY-MAKING IN SCHOOL AND HOME. By R. K. & M. I. R. Polkinghorne. New York: Frederick A. Stokes Company, 1920. 299 p.

To one who for many years has been preaching the value of a hobby as a part of mental hygiene, it is refreshing to find the following: "One need scarcely fear for the future of the child, however dull and mechanical her daily work as a grown-up person may be, if she has abundant interests in life—if she can use and love to use in leisure moments hammer, saw, and file, or if she has some other healthy hobby. Still, for those who like the pleasant noise and pleasant mess caused by tools, it is hard to find a happier occupation than toy-making. A toy-maker becomes at once a collector of useful odds and ends, and a collector—that is, one who collects willingly the things he likes—is always a happy person; the toy-maker becomes, too, the contriver, one who can adapt materials to different purposes, and the giver—for the finished article must be disposed of." If this is not sufficient to prove to the mental hygienist the value of manual work—and especially of toy-making—the reader is referred to the introduction to this book written by the headmistress of the County Secondary School, Streatham, in which she quotes from answers made to a questionnaire by ten- and eleven-year pupils, the first question being: "If you like handwork, say why; if not, say why you do not." "Out of forty-five papers, one answer was against handwork—'Because I do not like sawing.' " To the question, "Has it done you any good?" a fair number thought it made them careful or patient or more useful; others seemed to think that the exercise in sawing had some good effect on the arms; one said that her "fingers are better for music;" another that it has made her "not so flabby and fat." These are but a few of the delightfully naive opinions expressed.

The greater part of the book is given over to descriptions of toys and directions for making them. These are, as a rule, brief because the numerous illustrations—over five hundred—make much detail unnecessary. There is, however, no sacrifice of clearness. As may be imagined, the majority of the toys are simple of construction, in some cases so simple as to appear a bit crude, but these are intended for the younger children, the "infants," and it is emphasized that originality and a perfection of detail are to be encouraged. From these simpler toys there is careful grading to those more difficult of construction. An excellent idea is the construction of several group toys, such as a tournament, a mediæval market, or war engines of the past. These naturally stimulate the child to take a greater interest in his history lesson and secure a firmer association of the facts learned. There are also a number of mechanical toys that will appeal to the child who delights in machinery.

The book will be of value both to the teacher and in the home where there may be a child who likes to make things. The fact that English coins and other unfamiliar objects are used as comparisons will naturally stimulate the child to investigate them and so broaden his conceptions. The materials used are the simplest, and emphasis is laid upon the utilization of waste, which we suspect may be a minor hobby of one or both of the authors. The necessary tools required are very few in number, and ordinary household appliances are pointed out as substitutes.

To the teacher or occupational aid there is much that is stimulating in the book and many of the designs will be found to be likely to interest patients by their novelty. The book is heartily recommended.

W. R. DUNTON, JR.

Sheppard and Enoch Pratt Hospital

NOTES AND COMMENTS

Connecticut

A bill to establish a psychopathic hospital in New Haven at Yale University will be introduced in the 1921 legislature of Connecticut.

Illinois

The last General Assembly appropriated $1,000,000 for the construction of a group of research and educational hospitals in Chicago. Among the first buildings to be constructed will be a psychiatric institute, a new eye and ear infirmary, and an institute for crippled children. A joint agreement has been entered into by the University of Illinois and the Department of Public Welfare, whereby the university is to provide the professional service and the department to assume the administrative functions of the group. An interesting account of the movement to construct these hospitals, an outline of their purposes, and a description of them, with illustrations and floor plans, are found in the December, 1920, number of *The Modern Hospital*. The subject is reviewed from the standpoints of the university, the Department of Public Welfare, and the architects.

Massachusetts

The Psychopathic Department of the Boston State Hospital has been made a separate state hospital by legislative enactment. It is hereafter to be known as the Boston Psychopathic Hospital. Dr. C. Macfie Campbell, formerly of the Henry Phipps Psychiatric Clinic, Baltimore, is the new Medical Director. Dr. Douglas A. Thom will have charge of the out-patient department.

Minnesota

Interest is being expressed in the establishment of a state psychopathic hospital at the University of Minnesota. It has the indorsement of the State Medical Society, many state and municipal officers, and social workers. It is proposed to have a hospital of at least 70 beds to be placed in the university hospital group and conducted by the medical school under a joint arrangement between the university and the State Board of Control.

Tennessee

In September, 1920, a law was enacted to amend Chapter 150, Laws of 1919, establishing a state institution for the feebleminded, which was summarized in the April, 1919, issue of MENTAL HYGIENE.

The new law allows the Board for the Administration of State Institutions to select as a site property not belonging to the state, and carries an appropriation of $100,000 for the payment of the land and any necessary expense in establishing and opening the institution. The former law restricted the board to a site owned by the state and appropriated only $10,000 for the establishment of the institution in addition to an appropriation for maintenance.

Texas

The Northwest Texas Hospital for mental diseases, which was authorized by the 1917 legislature, is nearing completion. The East Texas Hospital, authorized the same year for colored patients, was opened September 1, 1919.

Virginia

A law to provide for the extradition of persons of unsound mind was enacted by the 1920 legislature. This law is similar to those in effect in Illinois, Maryland, Massachusetts, Nevada, Tennessee, and Wisconsin.

Chapter 262, Laws of 1920, has amended and reënacted certain sections of Chapter 46 of the Code of Virginia. These sections relate to insane, feebleminded, epileptic, and inebriate persons, including regulations pertaining to the institutions for their care, commitment procedure, and conveyance of patients.

Another act of the same legislature makes it a misdemeanor to marry knowingly any person lawfully adjudged to be insane, epileptic, or feebleminded. Any marriage shall be void without any decree of divorce or other legal process.

Chapter 339, Laws of 1920, relates to persons charged with crime whose sanity is doubted, persons becoming insane after conviction, and the disposition of those who are confined in the department for criminal insane charged with a crime. One of its outstanding provisions is for the commitment to a hospital for mental diseases or a colony for the feebleminded for proper care and observation of any person charged with crime, pending the determination of his mental condition, who appears to need such commitment. If the person is on trial, the trial may be suspended. The superintendent of the hospital or colony must inform the court of the condition of such person as often as the court may require.

FEDERAL AND STATE COÖPERATION IN BUILDING HOSPITALS FOR EX-SERVICE MEN

Last August the Hon. R. G. Cholmeley-Jones, Director of the Bureau of War Risk Insurance, sent an urgent appeal to the Governor of the State of New York to join with the Federal Government in providing a special hospital for the treatment of ex-service men and women suffering from nervous and mental diseases. The project, as outlined by the Director of the Bureau of War Risk Insurance and accepted immediately by the state, involves the construction by the state of a hospital for one thousand such patients, and its lease to the United States Government for a period of ten years at an annual rental amounting to one-tenth of the cost of construction. Although the legislature was in extraordinary session to consider housing legislation, the governor sent a special message, and on September 26 the bill was passed by both the Senate and the Assembly, becoming a law on September 27.

The Military Hospital Commission created by the act immediately began the preparation of plans, and on October 13 these plans were approved by the State Hospital Development Commission. After many weeks of negotiations, the Secretary of the Treasury decided that he did not have the power to sign the required agreement, and on December 10 he transmitted a letter to Congress requesting that he be granted such power by legislative action. A joint resolution was introduced in the Senate and the House of Representatives authorizing the Secretary of the Treasury to enter into an agreement to lease hospitals acquired or to be constructed by the state of New York or other states for the care and treatment of beneficiaries of the Bureau of War Risk Insurance. This resolution has been reported favorably by the House Committee on Public Buildings and Grounds, but unfavorably acted upon by the Senate Committee on Appropriations. Friends of the ex-service men in New York who are dissatisfied with the care such patients are receiving are unanimous in their demand that the hospital be constructed either through agreement with the government of the United States or, if the joint resolution fails, by the state of New York. Considerable interest is taken in other states in this project. Action by Congress on the resolution and action by the state upon the proposal that it proceed to build the hospital itself are awaited with much interest. This project is thought to be sufficiently important to justify printing here both the New York State act and the joint resolution:

LAWS OF NEW YORK.—By Authority.

Chap. 958

AN ACT to provide for the construction, by the state, of a hospital for discharged soldiers, sailors and marines, from the state of New York, suffering from mental diseases, and making an appropriation therefor.

Became a law September 29, 1920, with the approval of the Governor. Passed, three-fifths being present.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. A hospital is hereby established, to be constructed as herein provided, for the care and treatment of discharged soldiers, sailors and marines, suffering from mental diseases, who volunteered or were inducted into military service from the state of New York and who are or may hereafter become beneficiaries of the bureau of war risk insurance. Such hospital shall be known and designated as the New York Military Hospital.

§ 2. A commission is hereby created, for the purposes of this act, to consist of the state architect, the state comptroller, the attorney-general, a representative of labor and a member of the medical profession, to be appointed by the governor. Such commission shall serve without compensation and shall be known as the commission for military hospital.

§ 3. The commission for military hospital shall enter into negotiations and may make an agreement with proper authorities of the United States, whereby the state shall agree to construct such hospital and the parties shall agree that the state shall lease the same, when ready for occupancy, to the United States for a term not exceeding ten years at an annual rental, to be paid by the lessee, of not less than one-tenth of the total cost of such hospital; but the parties may estimate and determine the maximum cost on which such percentage shall be computed. The United States shall agree to equip, use and maintain such hospital, at its expense, exclusively for the care and treatment of discharged soldiers, sailors and marines mentioned and described in section one of this act. Provisions, satisfactory to the officers executing the agreement, and not inconsistent with this act, also may be included in relation to the care and treatment of the inmates of the hospital, and otherwise to carry out the objects and purposes of the hospital.

§ 4. Such hospital shall be located upon lands in the borough of Queens, city of New York, heretofore authorized by chapter four hundred and seventy-three, laws of nineteen hundred and eight, as a site for the Long Island State Hospital. Upon the organization of the commission for military hospital the jurisdiction granted by chapter four hundred and seventy-three, laws of nineteen hundred and eight, to the state hospital commission over the lands hereby selected as the site for the New York Military Hospital shall terminate.

§ 5. Such hospital shall have a capacity of one thousand beds and shall be constructed by the commission for military hospital. By this act an emergency is recognized, and the commission for military hospital, in the construction of such hospital, is hereby relieved from compliance with the provisions of the state finance law and the public buildings law relating to advertising, receipt of bids, the letting or making of a contract or contracts and the separate approval of contracts by the comptroller, and is hereby authorized to construct such work in any way deemed most advantageous for the completion of the hospital at the earliest possible date, and to enter into the open market and purchase materials or supplies, employ labor and make payments of bonuses in consideration of extra effort and efficiency or for overtime work. Such commission, and any contractor therewith, is also hereby relieved, in the prosecution of such work, from complying with requirements of the labor law in so far as they prohibit any person engaged upon such work from working more than eight hours during any calendar day. Contracts may be let and moneys expended, in the construction of such hospital and the purchase of land for a spur track, to an amount not exceeding three million dollars.

§ 6. Such work shall be done pursuant to drawings, designs, plans and specifications to be prepared by the state architect, and approved by the hospital development commission.

§ 7. When such hospital is ready for occupancy, the commission for military hospital shall execute, in behalf of the state, the formal lease to be made pursuant to the agreement provided for in section three of this act, which lease shall embody the covenants and conditions of such agreement. Upon the termination of such lease, such hospital shall be deemed a state hospital within the meaning of the insanity law.

§ 8. The sum of three million dollars ($3,000,000), or so much thereof as may be necessary, is hereby appropriated for the purpose of carrying out the provisions of this act, but no part of such appropriation shall be available for the acquisition of land for a spur track or for the construction of such hospital, until the agreement provided for in section three shall have been executed. The commission for military hospital is hereby relieved from compliance with the provisions of the civil service law and rules and may employ at any time such experts and other assistants as it may deem necessary for the proper development of plans, soil surveys, test pits, test borings and conduct of such work, and the moneys appropriated shall be immediately available for their compensation and expenses, and for the expenses of the commission for military hospital, either within or without the state. The moneys appropriated shall be paid out by the state treasurer on the warrant of the comptroller upon certificate of such commission or a majority of its members. Upon the requisition of such commission, the comptroller, from time to time, may advance to the commission such moneys as he shall deem necessary, from moneys appropriated by this act and available for the objects and purposes of the advancement.

§ 9. This act shall take effect immediately.

STATE OF NEW YORK, } *ss:*
Office of the Secretary of State. }

I have compared the preceding with the original law on file in this office, and do hereby certify that the same is a correct transcript therefrom and of the whole of said original law.

FRANCIS M. HUGO
Secretary of State

The following joint resolution (No. 223) was introduced in the Senate of the United States on December 14, 1920, by Senator James W. Wadsworth, Jr., of New York:

Authorizing the Secretary of the Treasury to enter into an agreement to lease, or to execute lease for hospitals acquired or to be constructed by the State of New York or other States of the United States of America for the care and treatment of beneficiaries of the Bureau of War Risk Insurance.

Whereas the State of New York has passed an act (chapter 958 of the Laws of 1920, State of New York) authorizing the construction of a hospital for the care and treatment of one thousand beneficiaries of the Bureau of War Risk Insurance suffering from mental and nervous disorders, and having appropriated therefor the sum of $3,000,000 for the construction of such hospital, and has provided a site in the city of New York, Borough of Queens, upon which said hospital shall be constructed, and

Whereas there is urgent need for additional hospital facilities for the care and treatment of veterans of the World War who have suffered injury or contracted disease by reason of their active military service: Therefore be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary of the Treasury is hereby authorized to enter into an agreement with the commission for military hospital of the State of New York, pursuant to the provisions of chapter 958 of the Laws of 1920, State of New York, to lease and thereafter to lease, in accordance with the provisions of said Act, subject to appropriations by the Congress of the United States, the hospital to be known as The New York Military Hospital to be constructed by said commission, when said hospital shall have been completed and ready for occupancy.

Sec. 2. That, subject to appropriations by the Congress, the Secretary of the Treasury is hereby authorized to enter into an agreement to lease with the duly authorized representatives of any State of the United States where governmental hospital facilties are urgently needed or to execute a lease for a period not exceeding ten years, and on such terms and conditions as he may deem proper, hospitals which have been acquired or constructed or may be acquired or constructed by such State for the purpose of providing additional hospital facilities for patients of the Bureau of War Risk Insurance.

Citizens of Colorado Vote for Psychopathic Hospital

With a majority close to 100,000, the citizens of Colorado at the November election voted favorably on a bill authorizing an appropriation for a state psychopathic hospital. The vote is particularly significant as this was not a fortunate year for initiated measures, as is shown by the fact that six of the ten initiated measures failed.

The Colorado Legislature in 1919, although it passed a bill authorizing the building of a psychopathic hospital to be located in Denver and to be under the auspices of the Regents of the University of Colorado, failed to pass an appropriation for construction. That the project might not fail at this point, the Colorado State Medical Society undertook to secure a sufficient number of signatures (some 18,000) to a petition initiating a bill appropriating $350,000 for the construction of the hospital. The task was an unprecedented one in medical legislation but the signatures were secured. Immediately preceding the election, an active general campaign of education was conducted. Audiences listened to discussions of the League of Nations, and of psychopathic hospitals and the care and treatment of patients with nervous and mental disease, from the same platform.

This is the first measure of its kind ever voted upon by an electorate in this country, and the Denver Psychopathic Hospital will be the first psychopathic hospital west of the Missouri River.

MENTAL DEFIENCY SURVEYS

During the year 1920, the National Committee for Mental Hygiene, through its Mental Deficiency Division, has conducted surveys in West Virginia, Maryland, Missouri, and Wisconsin. These investigations have been made at the request of the governors of these states, and in one state, Wisconsin, as a result of a joint resolution passed by the houses of the legislature. All of these surveys have been under the general supervision of Dr. V. V. Anderson, an Associate Medical Director of the National Committee.

The general aim behind the requests for such surveys has been the desire upon the part of public authorities and interested persons throughout the state to know how far the state was failing to meet the urgent needs of the mental defective; what was the extent of the problem; what its menace; its relationship to other problems, such as crime, pauperism, and the like; and, finally, in the light of information gathered, what ought to be done in order adequately to handle the situation.

In these surveys the National Committee has employed a staff of psychiatrists, psychologists, and psychiatric social workers; and the studies made have included not only investigations of the facilities now provided by these various states for recognizing, training, supervising, and segregating mental defectives, but a very careful investigation into the relationship that mental deficiency bears particularly to delinquency, dependency, and to education. In this way the inmates of state prisons, reformatories, industrial training schools, houses of correction, workhouses, jails, houses of detention, and delinquents passing through the courts have been studied in order to show what bearings mental deficiency has upon crime; inmates of state dependent schools, orphanages, almshouses, dependent families in connection with social agencies in cities and towns have been examined in order to determine the relationship that mental defect bears to dependency; and, finally, large groups of school children in typical public schools have been studied to find out what proportion of the public-school children are feebleminded and in need of special-class instruction or prolonged institutional care and training. In one state, Wisconsin, 7,000 school children in typical schools throughout the state have been studied; in West Virginia about 5,000 school children.

Constructive programs have been mapped out in each state to enable public authorities to meet the urgent needs of this large and potentially dangerous class.

In Wisconsin the following plan is to be presented for legislative consideration:

1. Compulsory mental examination of all children three or more years backward in their grades, utilizing for this purpose the psychological department already existing in the office of the superintendent of public schools and the occasional use of the flying clinic from the Psychiatric Institute.

2. Compulsory special-class instruction of all children in the public schools diagnosed mentally defective, these special classes to be developed more along the lines of handwork, manual instruction, and trade training than the ordinary academic and regular grade work of the public-school classes.

3. State-wide supervision of all feebleminded children needing such care; this after-care to be carried on under the direction of the State Board of Control.

4. Adequate institutional care for all feebleminded persons who cannot be satisfactorily handled under supervision in the community.

5. Parole, under carefully selected parole officers, of all suitably trained institutional cases fit for community life.

6. Mental examination of all inmates of the state industrial schools, dependent schools, state reformatory, and state prison; such examination to be conducted by a flying clinic from the Psychiatric Institute.

7. Mental examination of defective delinquents and other abnormal mental types in court. Permissive legislation enabling any court in the state to call upon the Psychiatric Institute for the services of a psychiatrist in attendance at the court.

8. Legislation enabling any judge to commit for a period of observation, ten or twenty days or more, to the Psychiatric Institute, any individual whose mental condition is in question.

9. The organization of special care for adult defective delinquents, using machinery already existing at the Central State Hospital as a basis for such work with males; using the new institution at Tachita for female defective delinquents.

In Missouri five important points have been stressed in the National Committee's recommendations:

1. More adequate institutional care for defectives: this to be accomplished by enlarging the Missouri Colony for the Feebleminded at Marshall, with the provision at this institution for additional facilities along the lines of manual, industrial, and trade training, and farm-colony treatment.

2. A new commitment law.

3. Organization of a traveling mental clinic to meet the needs of the public schools.

4. State-wide supervision of mental defectives in need of such care.

5. Reorganization of the present state machinery for handling insane, defectives, and epileptics, so that some constituted central authority shall have supervision and control of the state hospitals, the state institutions for the feebleminded, mental clinics in the public schools and in the community, and after-care work with the insane and defectives.

Missouri already has a compulsory special-class law.

In West Virginia there exists no separate state institution for the feebleminded. In this state some six hundred odd feebleminded persons are now being cared for in the three state hospitals along with the insane. It was deemed best in this state to concentrate upon two important points: the enactment of a proper commitment law, and the creation of a separate state institution for the feebleminded, equipped with the most modern facilities for the care, training, and treatment of mental defectives.

The Maryland survey will continue over into 1921, and a complete program has not as yet been mapped out for this state, although the need for larger institutional provision, special-class instruction, proper mental diagnosis of defective children in the public schools, and after-care work or supervision have already stood out as being very urgent questions in this state.

In each state, advisory committees have been appointed by the governor to assist the National Committee in conducting its surveys. The advisory committee in Wisconsin is composed of Dr. Cornelius Harper, Secretary of the State Board of Health, Chairman; Dr. W. F. Lorenz, Director of the Psychiatric Institute, Secretary; and Dr. Jos. Evans, Professor of Medicine, University of Wisconsin.

The field staff employed by the National Committee in Wisconsin consists of Dr. Smiley Blanton, Dr. Christine Leonard, Dr. Elizabeth Woods, and Miss Mina Sessions.

In Missouri the advisory committee appointed by the governor is composed of the following: Dr. G. Jones, Secretary, State Board of Health, President; J. L. Wagner, Secretary, State Board of Charities and Corrections, Secretary; Hon. Sam A. Baker, State Superintendent of Public Schools; Dr. Malcolm Bliss, President, Missouri Society for Mental Hygiene; Rhodes E. Cave, Chairman, Missouri Children's Code Commission; Charles A. Ellwood, Professor of Sociology, University of Missouri; Dr. E. J. Goodwin, Secretary and Editor, Missouri State Medical Association; L. A. Halbert, Secretary-Treasurer, Missouri Conference for Social Welfare; George Melcher, Director, Bureau of Research and Efficiency, Kansas City Schools; W. R. Painter, Chairman, Missouri State Prison Board; J. E. W. Wallin, Director, Psycho-Educational Clinic, St. Louis Public Schools; Dr. R. P. C. Wilson, Superintendent, Missouri Colony for Feebleminded and Epileptic; A. F. Kuhlman, Assistant Professor of Sociology, University of Missouri; J. Kelly Pool, Member Missouri State Prison Board; and Dr. E. J. Goodwin.

The National Committee's survey staff in this state are Dr. Thomas H. Haines and Mr. C. L. Hultgren.

In West Virginia the advisory committee appointed by the governor is composed of Dr. L. V. Guthrie, Superintendent, Huntington State Hospital, Chairman; Mrs. Woodson T. Wills, Vice-chairman; James S. Lakin and J. Walter Barnes, State Board of Control; L. H. Putnam, Executive Secretary, State Board of Children's Guardians; Dr. V. T. Churchman, State Board of Health; L. L. Friend, State Department of Schools; and J. S. Pauley, Secretary-Treasurer, State Federation of Labor.

The field staff is as follows: Dr. Frank J. O'Brien, Dr. Arabella Feldkamp, Dr. Esther S. B. Woodward, and Miss Elizabeth Greene. In this state Dr. Guthrie, Superintendent of the Huntington State Hospital, and Miss Davis, of the Board of Children's Guardians, were detailed by the governor to assist, and during the last few weeks of the survey, Miss Sarah Porter and Miss Mary Marshall were furnished by the state to assist in this work.

In Maryland the advisory committee appointed by the governor is composed of the following persons: Dr. Lewellys F. Barker, former President of the National Committee for Mental Hygiene; Dr. George Barnett, Professor of Statistics, Johns Hopkins University; Mr. Robert Biggs, President, St. Vincent de Paul Society; Dr. Edward N. Brush, President, Mental Hygiene Society of Maryland; Dr. William Burdick, Public Athletic League; Mr. Albert S. Cook, Superintendent, State Department of Education; Dr. Francis Lee Dunham, Psychiatrist, Maryland Child Labor Commission; Dr. Knight Dunlap, Professor of Experimental Psychology, Johns Hopkins University; Dr. J. N. T. Finney, State Board of Education; Mr. Charles Fox, Board of Labor and Statistics; Dr. Frank J. Goodnow, President, Johns Hopkins University; Dr. Arthur P. Herring, Secretary, State Lunacy Commission; Mr. Howard C. Hill, Executive Secretary, Prisoners' Aid Society; Miss Theo Jacobs, Associate in Social Economics, Johns Hopkins University; Mr. George Jones, Executive Secretary, Henry Watson Children's Aid Society; Dr. Frank J. Keating, Superintendent, Rosewood State Training School; Mr. Louis H. Levin, Executive Secretary, Federated Jewish Charities;

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The survey in Maryland is being conducted by Dr. William B. Cornell. Both Dr. Edith Michael and Miss Elizabeth Greene have at some time or other been employed in this work. During 1921 Dr. Cornell will be assisted by Dr. Christine Leonard and Miss Mina Sessions.

Comparable methods and similar technique have been employed in each state. The data obtained are therefore uniform in character and will lend themselves readily to comparative and cumulative treatment.

NATIONAL HEALTH COUNCIL

A conference of a number of the leading national voluntary health agencies was held in Washington on December 10, 1920, at which meeting a National Health Council was created, a form of organization approved, and a constitution and by-laws adopted. The membership of the council is at present composed of nine organizations, the officers recently elected being as follows: Chairman, Dr. Livingston Farrand; Vice-Chairman, Dr. Lee K. Frankel; Recording Secretary, Dr. C. St. Clair Drake. The election of a treasurer was deferred until further consideration could be given to the whole question of financing the project.

The council was the outgrowth of many efforts in past years to coördinate national voluntary organizations, initiated by the American Public Health Association, the American Medical Association, and other agencies. These measures culminated in a special health coördination study carried out during the summer of 1920, under the direction of Dr. Charles J. Hatfield, Dr. Watson Rankin, and Dr. Livingston Farrand, with the financial aid of the American Red Cross. This investigation was conducted by Dr. D. B. Armstrong.

At a preliminary conference in Washington, at the call of Dr. Farrand, on October 18, 1920, the need for such a coördinating body was fully discussed, and a temporary organization perfected, Dr. Farrand acting as Temporary Chairman, and Dr. Armstrong as Temporary Secretary.

The organization conference on December 10th, referred to above, approved of the following list of activities, as indicating the legitimate field in which the council might function:

1. A special information bureau
2. A legislative bureau
3. The coördination of health activities
4. Periodic joint conferences
5. A statistical bureau
6. The development of educational health material.

It is anticipated that financial resources, from the Red Cross and from other participants, will be sufficient to enable the council to establish an office and staff and to undertake first those activities promising the greatest benefit to member organizations.

In accordance with the by-laws adopted by the council, each member organization has appointed one representative and one alternate. The original members are as follows: American Public Health Association, American Red Cross, American Social Hygiene Association, Council of State and Provincial Health Authorities, Council on Health and Public Instruction of the American Medical Association, National Child Health Council, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Tuberculosis Association.

The by-laws provided that "other national health organizations may hereafter be elected to membership by 2/3 votes of the members." Provision is also made for advisory or conferring, as well as directly participating, members. The International Health Board probably will, together with official agencies such as the United States Public Health Service, be associated with the council in this capacity.

Many important matters before the council, given partial consideration at the last conference—such as office, staff, budget, resources, etc.—were referred to a subcommittee made up as follows: Dr. William F. Snow, Chairman; Dr. C. St. Clair Drake, Dr. Charles J. Hatfield, Dr. Lee K. Frankel, with the council chairman, Dr. Livingston Farrand. It is expected that this committee will report its deliberations to the council at a meeting early in January, following which the organization should be in a position to proceed with the development of its program.

The Public Health Council, representing as it does many prominent national health agencies, should serve as a valuable clearing-house and coördinating center in many fields where common functions are performed. It aims to be an integrating force among independent, autonomous agencies, rather than a merger of such agencies into one organization. It should increase the economy and effectiveness of operation, should eliminate duplication of effort, and should enhance opportunities for sympathetic and constructive public service. Such a movement, through its membership, and through a mutually helpful relationship with state and local voluntary health agencies, should effectively serve the declared object of the National Health Council, which is "the betterment of health work in the United States."

MENTAL HYGIENE IN FRANCE

Dr. Paul-Maurice Legrain, Chief of Medicine in the French Cabinet, has recently been in the United States studying the mental-hygiene movement. In the department of medicine in the French Cabinet there is a division devoted to the study of mental hygiene. During the war, Dr. Legrain was Psychiatrist of the District of Paris and, as a part of his work, handled all military questions with medico-legal aspects.

MISSOURI SOCIETY FOR MENTAL HYGIENE

A meeting was held in the office of Dr. M. A. Bliss, 301 Humboldt Building, St. Louis, Missouri, on the 26th of last November for the purpose of organizing a Missouri Society for Mental Hygiene. Those who attended the meeting were Dr. George Johns, Superintendent of the City Sanitarium, Dr. James McFadden, Dr. Frank R. Fry, Mr. Emil Tolkacz, former Director of Public Welfare of the City of St. Louis, Dr. M. A. Bliss, and Dr. Thomas H. Haines, Director of the Missouri Mental Deficiency Survey. Judge Charles W. Holtcamp, of the Probate Court, and Judge Hugo Grimm, of the Circuit Court, who had expected to be present, but were detained, later expressed their hearty coöperation in the plans adopted at the meeting, and agreed to act as members of the organizing group.

Dr. Bliss was elected president and Dr. McFadden secretary of the new society. At the suggestion of Mr. Tolkacz, it was decided that each member of the group should make out a list of persons whom he considered likely candidates to help in organizing the first board of directors; that Dr. McFadden and Dr. Bliss should compare these lists and eliminate duplications; and that each member of the group should then receive a revised list with a form letter, which he would send out as a personal letter to the people on his list. It was felt that the personal touch would be of value in such an organization program.

Later reports state that responses to these letters have been most encouraging, as a large number of acceptances have been received from persons prominent in the various professions and representing a wide range of civic interests.

MENTAL HYGIENE; AMERICAN PUBLIC HEALTH ASSOCIATION

One of the largest attended section meetings at the meeting of the American Public Health Association, held in San Francisco in September, was the session of the Sociological Section on mental hygiene. The following papers were read: *Psychiatry and Public Health,* by Eva C. Reid, M.D.; *Mental Health of Children,* by Glenn E. Myers, M.D.; *Social Aspects of Mental Defect,* by Harold W. Wright, M.D.; and *Public Health Education and Mental Hygiene,* by Frankwood E. Williams, M.D. Among those who took part in the discussion were Dr. Olga L. Bridgman, San Francisco; Dr. F. W. Hatch, Sacramento; Dr. Andrew W. Hoisholt, Napa; Dr. C. W. Mack, Livermore; Dr. Lillian J. Martin, San Francisco; Dr. V. H. Podstata, Livermore; Dr. Robert Lewis Richards, Talmage; and Mr. August Vollmer, Berkeley.

CORRECTION

The editors regret an error that was overlooked in the copy of the article *State Institutions for the Feebleminded,* published in the July, 1920, number of MENTAL HYGIENE. The statement "so that now only five states in the Union have failed to make any institutional provision for their feebleminded, West Virginia, New Mexico, Arizona, Nevada, and Idaho," should be changed to read, "so that now only five states in the Union have failed to make separate institutional provision for their feebleminded, West Virginia, New Mexico, Arizona, Nevada, and Utah."

THE AIMS OF MENTAL HYGIENE

"To stem the tide of syphilis, to wage war on alcohol, to counsel against marriage of defectives, to generalize the insane hospitals, to specialize the general hospitals, to weed defects out of general school classes, to open out the shut-in personality, to ventilate sex questions, to perturb and at the same time reassure the interested public—these are infinitives that belong perhaps in a rational movement for mental hygiene. They are things the past has taught us more or less clearly to do and in that sense the movement for mental hygiene is surely not much more than the elaboration of the obvious."—*E. E. Southard.*

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AUGUST–NOVEMBER 1920

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MENTAL HYGIENE

VOL. V APRIL, 1921 No. 2

MAL-BEHAVIOR VIEWED AS AN OUT-PATIENT MENTAL AND NERVOUS CLINIC PROBLEM*

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THE principles that govern an out-patient clinic for mental and nervous diseases can never be reduced to the simplicity of organization and method that may obtain in the eye, ear, or nose and throat dispensary. From the nature of the problems that they present, neuropsychiatric patients will always remain immensely more difficult and complicated, in respect to diagnosis as well as to treatment. A major part of this difficulty naturally arises from our deficiency of knowledge concerning the etiology of mental and nervous pathology and of allied conditions.

From an analysis of considerably more than one thousand out-patients, two features are so frequently repeated that they acquire a certain significance for any one attempting to formulate a set of principles for a neuropsychiatric clinic. The first relates to the reasons that bring the patient or cause him to be brought into contact with this special service. Almost invariably these reasons may be summed up under the general heading of *mal-behavior.* The word is used in its broadest significance as opposed to good or normal or, perhaps better still, average behavior. It does not necessarily mean antisocial conduct, but any sort of conduct arising from disease that lowers or lessens the morale, efficiency, and progress of the individual and therefore of the family and the community. It is obvious that the individual with a psychosis who is perhaps dangerous to his family and neighbors is easily assignable to this group. Of course, the same is true of the mental deficient who is low grade enough to be a public charge, and perhaps more so of those with higher degrees of feeblemindedness who menace the community by their inefficiency, their tendency to spread disease, and especially by the frequency with which they produce new generations of deficients. However, we usually do not think of mal-behavior in connection with the child who is somewhat retarded or the adult who is suffering from the result of a trauma to an important peripheral nerve. Yet both patients not only have their own efficiency impaired, but also lower the efficiency, morale, and general well-being of the community. Unless the condition of the child is promptly corrected, he will lose the advantage of a sound educational foundation, which will lessen his chances of future success and usefulness; further, he claims an undue amount of the teacher's attention, and thus in some degree retards the advancement of the other school children. Likewise the adult, as long as he has his nerve disability, is an economic liability and he and his family are apt to be more or less dependent on society. Therefore, we have to do in each instance with a problem that involves an inability to adjust, or mal-behavior. The difference between the case of dementia praecox and the organic neurological case from this point of view is, after all, a difference of degree, and the effect on the community is of the same kind. Since every problem that comes to the mental and nervous clinic may be most easily regarded in this way, it is proposed that the principle that activates the clinic should be the *study of mal-behavior, an investigation of its causes, and an effort to correct its ill effects.*

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* Expanded from an extension lecture on the *Problems of Behavior* delivered at Sleighton Farms, May 24, 1920, under the auspices of the Pennsylvania School for Social Service.

The second principle is related to the incompleteness of our clinical and pathological knowledge. When we really do not know, it is not safe to assume or to theorize, especially if our theories mean that etiologic possibilities are to be excluded in actual practice. Even in out-patient work where a great number of patients must be seen in a comparatively short time, it is necessary to take many steps in attempting to reach a diagnosis. For instance, a collection of vague somatic complaints may not be dismissed as essential neurasthenia. There may or may not be important underlying physical factors. At least, as a matter of simple justice to the patient, they must be carefully searched for. This makes it imperative that the clinic have access to all possible sources of diagnostic information. The resources of the internist, the surgeon, the ophthalmologist, the laryngologist, the otologist, the rhinologist, the gynecologist, the urologist, the syphilographer, and the dentist, the assistance of the laboratories of physiology, of roentgenology, clinical pathology, and chemistry, and the help of the psychologist must all be focused on our difficult problems. Our own errors and the experience of others have impressed on us the wastefulness and danger of neglecting these aids to diagnosis. Therefore, the second principle should be that the clinic be not highly specialized, but *highly generalized.*

To illustrate these points, a number of summarized case histories are presented. They are selected because they represent large groups and are, with certain individual modifications, examples of constantly recurring types. These problems and the measures required for their study, diagnosis, and treatment represent the daily routine work and demands of the clinic.

MAL-BEHAVIOR DUE TO PHYSICAL CAUSES

Case 1: A Canadian soldier, twenty-three years old, before his return from the war was a quiet, bright, ambitious young man. He was the main support of a widowed mother. Soon after his discharge, there was a striking change in his personality and behavior. He became irritable, vulgar, overbearing, fault-finding, threatening, and bombastic. Employment was out of the question, as he had not the slightest realization of his responsibilities. There was paresis of the right side. The neurological examination and the serological studies pointed to central nerve syphilis, probably in a gummatous or vascular form. Under intensive treatment the signs and symptoms cleared up and the abnormal behavior traits entirely disappeared.

Case 2: A widow of thirty-seven, who has four children, was brought to the clinic by a social worker from whose report I quote the following: "Her house showed signs of neglect; the kitchen was filled with dirty dishes. She complained a great deal about her sad life and said that every one was imposing on her. At times, she was defiant, and again wept throughout the visit, reiterating that the children would drive her insane. There was absolutely no effort to discipline the children. She spoke of severe frontal headaches. She feared that she might lose control of her 'nerves' and become violent."

The difficulty was of one year's duration. Previous to that time, she had operated a five-pound hammer at a steel mill. The patient had been under treatment for eleven months, and the diagnosis was neurasthenia.

During the first ten minutes of the examination, it was discovered that the blood pressure was 215. Further study made it evident that this woman's mal-behavior was largely conditioned by important organic changes of which the unusually high pressure was one manifestation. Under proper treatment, which will begin with rest in a convalescent home, it is probable that this patient can be restored to some degree of efficiency and usefulness.

This case illustrates the fallacy of neglecting the *ordinary* means of diagnosis. If we disregard them, we may easily be led into grave errors whose consequences may have to be reckoned in terms of life.

Case 3: A married woman, twenty-eight years old, who has four young children, was brought to the clinic because her house was filthy and she was apathetic about herself and indifferent as to the condition of the children. According to the Binet scale, she was nine years old. At the time of her marriage in 1911 and for several years following, she had been apparently normal.

The physical examination was interesting. The patient was heavy and slow. There was thyroid struma. The skin and underlying tissues were myxœdematous; the hands and fingers were thick and puffy, and the features coarse; the pulse was sixty. The tonsils were greatly enlarged. Basal metabolism was low. There seemed enough clinical evidence to justify a diagnosis of hypothyroidism.

Under thyroid medication, there has already been very definite improvement. The weight is fifteen pounds less, and the physiognomy is more distinct and clear-cut. The patient is brighter, more interested, and takes better care of her children and house. The outlook for the future is very promising.

Case 4: A girl of twelve was brought to the clinic because she was "backward," "troublesome," and constantly being returned as "undesirable" by the various families with whom the aid society attempted to place her. The consensus of numerous opinions was that the child was forgetful, sluggish in her movements, gluttonous, indifferent, and sleepy. So hopelessly was she outclassed at school that it seemed useless to continue to send her.

Examination revealed a girl 61 inches in height, weighing 165 pounds, with a relative increase in the length of the long bones. There was a pathological amount of fat. Intellectually, the patient was 7.5 years old. We were able to determine by certain bio-chemical investigations that there was an usually large tolerance for glucose and other sugars, which disappeared under large doses of pituitary extract. Appropriate therapy has resulted in a brighter child, no longer apathetic, gluttonous, or physically sluggish. A very fair degree of school progress is being reported.

Here are four mal-behavior problems dependent on physical causes. The determination of the diagnosis, which was absolutely necessary in order to interpret the conduct disorder, was not as simple as may appear from the brief summaries. We had to go far beyond routine methods and seek the help of the more unusual procedures. For instance, without the roentgenologist and the bio-chemist, we could not have reached a logical conclusion. This method of approach is expensive, but it is absolutely necessary and is very apt to produce results. Psychiatry, as applied to even out-patient work, must therefore undertake more than mere formal physical, mental, or psychological examinations. It must take advantage of every refinement and advance in modern medicine if it ever hopes to unravel the tremendously complex puzzle of human behavior.

MAL-BEHAVIOR APPARENTLY DEPENDENT ON PSYCHOGENIC FACTORS

The following is an example of a wholly different problem:

Case 5: A young man of twenty-two, formerly bright, efficient, a hard worker, but overconscientious and inclined to be introspective, returned from the war in a very serious mental state. He was depressed, and although there was considerable insight, he viewed the future as very dark and threatening and his thoughts easily turned to suicide.

Physical examination revealed a general condition of fatigue, but no organic disease. After a modified rest treatment, he was approached from the standpoint of mental investigation and suggestion. Finally our patient told us of a sexual irregularity of a rather serious character that had occurred eight years previously. It is impossible to evaluate properly any factor, particularly a psychogenic one, but the patient did experience evident relief after he had confided his "terrible secret," and improvement set in when this episode was placed before him in its true light. It was ultimately possible to reëducate him to a practically normal point of view.

Case 6: A young woman of twenty-eight presented many inhibitions. She termed them "influences" and was hopeless about the future unless they could be removed. They interfered with every act of daily life, even with her speech, her gait, and her thoughts. A long process of reëducation has seemingly enabled her to make an adjustment and go on with her life. It is interesting to note that there were or had been practically no unusual mental or actual sexual situations and that other difficulties were much more significant. Incidentally, there was a moderate degree of pyorrhea, which was treated.

Here we have two patients in whom there were conduct disorders severe enough to interfere with even the ordinary routine of social intercourse. There were apparently only minor physical disturbances, and therefore psychiatry as applied to them, as far as we could determine, meant the unraveling of situations that had a pathologic-psychogenetic basis.

Conduct Disorder with a "Mixed Etiology"

Case 7: A widow of twenty-eight was brought to the clinic because she neglected her four young children. She was "nervous," worried, cried frequently, and constantly felt a lump in her throat. There was insomnia, headache, "sparks" before the eyes, a numb sensation in the hands, and a feeling in the head as if two close-fitting wheels were "grinding together."

This patient inherited a neurotic make-up. Further, there had been several unusual and terrifying experiences. At the age of twelve, she had discovered her father hanging from the staircase—a suicide. Shortly before this, she had witnessed the death of an older sister by drowning. Some years later there was a fire in the factory where she was employed, and the patient became rigid and unconscious. Her husband died of tuberculosis about a year ago.

We began our study of this patient with a thorough physical examination, which revealed an inactive tuberculosis, a beginning hyperthyroidism, a badly lacerated perineum and uterus with inflammatory discharges, advanced pyorrhea with many apical abscesses and a chronic otitis media with an offensive discharge.

The course of treatment was first complete rest in a convalescent home; then the teeth roots were extracted, the ear condition cleared up, and the torn pelvic structures repaired by operation.

Hand in hand with these reconstructive measures, there were psychotherapeutic treatments. After the patient's confidence had been gained, she talked freely of her life, which had been filled with disappointments and trials. She was undoubtedly helped by an attitude *of understanding, not of sympathy,* and given a more hopeful viewpoint.

The following case is somewhat similar:

Case 8: A girl of eighteen was brought to the clinic with the idea of having her committed to a mental hospital. She had been ill for three years, following an ear operation. She complained of a constant whirring sound in the head and said that people and things seemed unreal as if they were "far away." She had laughing and crying spells and was very seclusive. A private physician told her she was "affected," and then she attempted suicide by drinking lysol.

In the physical examination were discovered moderate anæmia, rhinitis, a severe purulent otitis media, and a possibility of internal hydrocephalus.

The plan of attack was similar to the one adopted in the previous case in that it was a combination of physical therapy and psychotherapy. As a measure of treatment, she was permitted to assist as typist in the social-work department. After some months, this patient had regained enough confidence and stability to take a position with a large publishing house. Recently she was offered more important work at an increase in salary. She is doing very well and is entirely recovered.

These two cases may be properly designated "mixed" because there were physical and psychogenic factors, both of which were important. No single method of therapeutic attack was indicated. In other words, if the physical condition had not been discovered or had been neglected, then even the most expert psychotherapy would have been utterly futile. On the other hand, if the point of view had been exclusively organic, then even careful physical attention would have left an unfinished problem. It seems imperative that a psychiatrist be not committed to any single outlook or else he will be helpless in the face of many situations that must be met.

Mal-behavior Resulting from Economic and Environmental Factors

The following two cases may be briefly summarized to show the effect of economic and environmental circumstances:

Case 9: A child of thirteen did not get on well in school and was listless and indifferent. Her psychometric age was nine years. There was no organic disease, but a general appearance of poor nourishment. The family were instructed in the principles of hygienic living and food values. The coöperation of the teacher was obtained. Now our little patient proudly brings her monthly school records to the clinic, and they, together with the reports of the teacher and social worker, indicate that she is rapidly forging ahead in her class.

Case 10: An even more simple problem is furnished by a rather bright boy of nine. His Binet age is 8.5 years, but he is only in the second grade. He is the ward of an aid society and the victim of numerous placements. Necessity forced him to attend at least a dozen schools, and never did he have an uninterrupted term of schooling. A permanent placement and special training will soon bring this patient up to the average level.

Psychotic Mal-behavior

Case 11: A woman of thirty-four, separated from her husband, has the following history: Constant domestic difficulties culminated in a divorce, with all but one of five children, a seven-months-old baby, placed in the custody of the husband. It was shown in court that the mother had neglected the children, did not send them to school, and spent much time on the streets. She dressed beyond her means in odd, conspicuous clothing, and went to the "movies" with other men. The husband asserted that she was lazy, extravagant, had a violent temper, and often threatened to do him bodily harm. The patient was examined at this time and diagnosed psychoneurotic. She was then cared for by a social agency, but was so unreliable and so utterly unable or unwilling to coöperate that she was brought to the clinic for examination.

The patient has distinct delusions of persecution, all referred to her husband. He annoys her in every possible way, hides behind poles to spy on her, induces women in the neighborhood to accuse her of immoral conduct. There are visions that make "mean" remarks. At times she has gastro-intestinal pains, which are due to poisoned food. Her husband wants to kill her so that he can marry another woman.

Here is a reaction that is due to a psychosis. It is not only a type of mal-behavior, but is an active antisocial tendency springing from a delusion. It may lead to serious consequences—even to homicide. The application of psychiatry in this instance made possible the admission of the patient to a hospital for mental diseases.

Mal-behavior in Constitutional Psychopathic Inferiority

The following three cases belong to the same group and represent gradations of varying intensity:

Case 12: A colored girl, aged seventeen, was brought to the clinic for a decision as to whether she should be sent to a reformatory. According to the history, she is a ward of an aid society and has had several placements. One of them was moderately successful; in another, she evidently gave considerable trouble. She was accused of sullenness and disrespect, of lying, and of pilfering several small articles. The patient herself admitted her ill-behavior. An impartial investigation of the placement makes it altogether probable that there was not only injudicious, but also harsh treatment.

Examination revealed a mentally retarded, not mentally deficient girl with some of the stigmata of congenital syphilis. The serology was negative. The patient was somewhat inadequate and corresponded to the so-called psychopathic-inferior type. She had some fairly reasonable plans in mind and wanted to learn how to be a good cook.

Here is a type of mal-behavior probably conditioned by both heredity and environmental factors. As there seemed to be a fair chance for reconstruction, a new placement was reommended. The patient will be carefully supervised by a social worker.

Case 13: A more difficult situation is presented by a woman of forty-four with the following history: There are six children, all illegitimate, "by at least three different fathers." "The patient formerly earned $30.00 a week as a restaurant cook, but gave up the work because it was too hard. She refuses to give up a male lodger or to send the children to the day nursery."

Examination and observation at the clinic showed that the patient is not mentally defective. She is unmoral rather than immoral, with practically no appreciation of the seriousness of her lapses. At first we were inclined to take steps at once to attempt to remove the children, but finally decided to make certain minimum requirements and to give the patient an opportunity to try to live up to them. The following considerations entered into this decision: The woman is apparently genuinely fond of her children and takes reasonably good care of them. She has probably abandoned her immoral life. Furthermore, she is past the child-bearing period.

There has been some encouragement. She has returned to work, and the boarder has left the house. We are not at all certain that our plan will be successful. However, with supervision there is no great danger, and it is just possible that if this woman is kept up to the limit of her capabilities, she may fill a place in life with some credit and find satisfaction in keeping her children together.

Case 14: The third patient of this series is a white woman of thirty. For a number of years she lived with a Negro, twenty-three years her senior, and by him had five children. This man already had a common-law wife and five children. The patient became pregnant by another man, who has active syphilis. Through an order of the court, they were married and lived together. There are details of various sexual perversions, which need not be included in this report. The home conditions investigated by an experienced and careful social worker are beyond description.

This woman, when examined at the clinic, was perfectly frank. She had absolutely no appreciation or understanding of the enormity of her own moral and social degradation. Her moral sense was less acute than that of a child of five. Intellectually, she was not deficient to a committable degree.

Here is a case about which we need not hesitate as to the course to be pursued. Steps have already been taken to have the children removed from the pernicious influence in which they have been living. If it is at all possible, the woman will be segregated. Unless this or something similar can be accomplished, we venture to say that in the future the social liabilities that may be traced to this woman will eventually rival those of the well-known Kallikak family.

These three patients belong to the constitutional-psychopathic group which is ill defined and has many ramifications. Here we find the inadequate personality, the criminal, the moral degenerate, the sexual pervert, the paranoid personality, the emotionally unstable, the pathological liar, etc. Here we may look for not only mere deviations in conduct, but often vicious and asocial behavior, which threatens not only the individual, but the stability and progress of society in general. It is much more dangerous than frank, committable feeblemindedness, because often these constitutionally inferior individuals fall short of the commission of overt acts, and the medical viewpoint is frequently not acceptable to legal judgment. Fortunately some of these patients are at least partially responsive to environmental control and reconstructive and supervisory measures. The psychopathic state seems to be the product of congenital handicaps plus training deficiencies.

FEEBLEMINDED MAL-BEHAVIOR

Case 15: A girl of twenty was brought to the clinic for an opinion. Her specific form of mal-behavior was represented by a seven-months-old illegitimate child. Examination demonstrated that the patient was an imbecile. A consideration of her history forces the conclusion that she should have been placed in an institution for mental defectives two and a half years before; the illegitimate child could thus have been avoided. At that time the patient was in a hospital for mental diseases. She remained there for three months, was carefully studied, correctly diagnosed, and discharged with the recommendation that she be placed in a suitable institution. This advice was not followed and the delay has meant the birth of an illegitimate child. Unfortunately, mental deficiency is largely a question of heredity.

COMMENT

Let us briefly consider these fifteen cases from the following standpoints: the type of mal-behavior presented and its effect not only on the individual, but also on the family and community, the cause of the conduct disorder, the diagnosis, and the outlook, not only in a personal sense, but also in its broader social significance. In the first place, thirteen individuals were made absolutely inefficient and two children partially so. Further, in eight instances a family or dependent was directly affected by the inefficiency and disability of the main source of reliance. Twenty-seven children were neglected. One of these, an infant, was physically endangered through exposure; and five children were constantly in the presence of syphilis in a dangerous stage. One case might have eventuated in suicide; another in homicide. Almost every patient was a dead loss to the community and necessarily lowered the social morale. In addition, one woman was a public menace because of threatened violence; one constitutional psychopath, who had already given birth to four illegitimate children and was extremely apt to have more, furnished also a constant source of danger to the community as her husband was passing through a virulent stage of syphilis; and a feebleminded girl with an illegitimate infant was permitted to be at liberty at the beginning of the child-bearing period. Could out-patient psychiatry ask for a more fertile field on which to expend its labors?

Although our fifteen patients show marked personal variations in the type of mal-behavior presented, still these may be reduced to four main headings—physical, psychogenic, economic and environmental, and congenital. In four instances, there was a distinct physical reason; in two, the underlying factor, as far as could be determined, was psychogenic; in two, there was an admixture of physical and mental mechanisms; in two, economic and environmental factors were at fault; and in the remainder may be recognized the influence of this latter element and inherited defect, sometimes the one and sometimes the other being the more prominent.

The final diagnoses were as follows: cerebro-spinal syphilis, hypothyroidism, heart and kidney disease, hypopituitarism, mental retardation, psychosis, psychoneurosis, constitutional psychopathetic state, and imbecility. Seven of the patients had been previously studied by medical and social agencies and an opinion had been formed. A case of supposed paresis proved to be a more hopeful form of syphilis; two "neurasthenics" in reality had heart and kidney disease and thyroid deficiency; one "psychoneurotic" was dementia praecox; and three "feebleminded" children were only retarded, one because of hypopituitarism, and two as a result of economic and environmental factors. Thus, in all but one instance the outcome of extended study resulted in a more optimistic viewpoint. What has been accomplished by bringing these patients to a clinic for mental and nervous diseases? In other words, has there really been an intelligent application of psychiatry to the problems of mal-behavior? Has it been worth while? What has been the net gain to the individual, to the family, and to society? Six patients recovered, which means that five adults became self-sustaining, directly affecting five dependents, four being children, while the sixth case, a child, was practically restored to a normal intellectual level; five patients were greatly improved as to personal efficiency and self-supporting powers, which meant that the condition and environment of fourteen children were very favorably influenced; two patients, one mentally ill and one defective, have been placed in proper institutions. One child has been separated from a mentally abnormal mother, another from an imbecile parent, and five removed from a hopeless and dangerous environment. The public has been saved from possible violence and protected from a source of venereal disease. Multiply the number of patients by fifty or one hundred and it would seem that the gain to individual, family, and community has been marked enough to constitute a convincing argument for the importance and value of the application of psychiatry to conduct disorders as met in an out-patient clinic.

The final lesson which these cases should teach concerns the attitude of mind with which the physician should study the patient. It is evident that no single method or theory would have served in every instance. In other words, the general problem of mal-behavior is exceedingly complex and will not yield a solution to any one system. It may rest on a physical, psychogenic, congenital, or environmental basis, or on combinations of two or several of these factors. In the present state of our knowledge, too much enthusiasm about any school or belief may be dangerous. It should be feasible to have all possibilities in mind and be individual and open-minded enough to follow the rational one for each patient.

PSYCHIATRY AND "SCIENTIFIC PSYCHOLOGY"

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IN the last issue of MENTAL HYGIENE, the writer had occasion[1] to mention the antagonism at present existing between psychiatrists and what we may term "academic psychologists." Approaching the problem of human behavior from two widely separate angles and examining phenomena of different types, each school has ventured rather sweeping hypotheses to cover *all* mental phenomena. Since these hypotheses are in conflict, their proponents have not been scientifically friendly. This puerility could be ignored by the general public were it not for the fact that each school is desirous of applying its theories to the solution of pressing social problems and is resentful of the presence of the others in the field. Both the psychiatrists and the psychologists insist that they are the ones who should direct the study and treatment of those mental abnormalities which lead to social unrest, economic insufficiency, and crime, as well as to frank nervous and mental disease. What has been a private professional quarrel is becoming one in which the public will be forced to participate. If this interference is to be intelligent, the public must know something of the claims, and the basis for them, of each of these groups.

The subject is a large one, and no single article can touch upon more than one phase of it. It is proposed now to discuss one publication[2] of an avowedly polemical nature, as it is typical of the arguments of the academic psychologists. The author holds a distinguished position both officially and professionally, and claims to speak for his school. It is true that his attack is directed against one subgroup of psychiatrists—the psychoanalysts—but his basic arguments are against the methods and hypotheses of many psychiatrists whose field of inquiry is clinical and who find the hypothesis of unconscious mental operations to be essential. It is, therefore, safe to assume that Professor Dunlap is really inveighing against those who work from another standpoint than that of the academic psychologists, rather than against the followers of Freud alone. In making the latter the target for his criticism, he shows tactical wisdom. "Freudianism" has become dangerously popular; there is no control over those who practice or preach it, and in consequence the wildest, most uncritical claims have been published. To fill a book with quotations of this order would be a simple task. If Dunlap's publication were written to warn the public against these excesses alone, it would have great value. Unfortunately, however, he uses this situation to provide atmosphere for an attack on principles fundamental in much psychiatric work and theory. He endeavors to show that the psychoanalytic "unconscious mind" is a scientifically pernicious hypothesis, historically the child of "the philosophical mystic's third kind of knowledge" and practically identical with it. Behaviorism is similarly tainted by its origin in the unscientific doctrine of psycho-physical parellelism. The one true light shines in the study of the "scientific psychologist." This raises a direct issue, not of the expediency of one method of study or another, but of scientific logic. His work, therefore, challenges criticism. Are his criticisms logical? Is his own theory free from logical error? If so, there can be no doubt that opposition to his school should be smothered. He does not look for the relative truth of one view or another, but claims the absolute.

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[1] In a review of H. L. Hollingworth's book, *The Psychology of Functional Neuroses*. MENTAL HYGIENE, Vol. V., pp. 181-189, January, 1921.

[2] *Mysticism, Freudianism, and Scientific Psychology*. By Knight Dunlap. St. Louis: C. V. Mosby, 1920. 173 p.

The matters involved are so fundamental, scientifically as well as socially, that the issue should be met and the question settled in the open light of public discussion. If what he alleges be true, the progress of science will be impeded by the spread of psychoanalysis and this psychiatric viewpoint generally, and public opinion should be aroused against them. Should he be as flatly wrong as he claims his opponents to be, a similar nemesis should, presumably, overtake him and his works. The layman, who ultimately supports both the practice of medicine and the teaching of psychology, is entitled to hear the argument. Hence this review. When the dust rolls away, the judge will probably decide that each combatant was guilty of trespassing on the other's proper field of labor, and will reserve his condemnation for him who has fought unfairly.

Professor Dunlap's book of 173 pages is divided into three chapters, dealing severally with the history and nature of mysticism, with the theories of psychoanalysis, and with the methods of "scientific psychology." The text is written with admirable clearness, which makes its reading as easy as that of any such work can be. The critic's task is lightened by a flat dogmatism of statement, which frees one from the fear of misunderstanding the argument and of being unfair in consequence.

The discussion of mysticism may be briefly digested. There are two recognized kinds of knowledge—the sensuous and the intellectual, or the perceptual and the ideational, or, as Dunlap prefers, "the knowledge of sense perception" and "the knowledge of inference and reason." For at least fourteen hundred years, mystics in Europe have insisted that there is "a *third kind of knowledge,* which, according to the mystic evaluation, ranks higher than either of the other two. It is not necessarily higher in the sense of being more complex, or of being the result of a longer temporal course of development, but higher in value. This theory of a third kind of knowledge is the essential and fundamental point in mysticism."

"In so far as we are able to examine and analyze the mystic experience secondhand from the reports of the mystics, we find certain characteristics which make it probable that the mystic experience is actually an intense emotional state—which, indeed, leave us little reason for supposing that the experience is anything other than emotional. On this account we have no reason for attempting to explain the mystic experience on other than common psychological grounds, and we have, therefore, no reason for doubting the facts of the experience and the good faith of the mystics in their attempts to describe it. In ecstasy or union—the noetic state which transcends all psychological cognition—the really cognitive elements are induced well towards the zero point, leaving an emotional state which is almost purely affective and which is evidently exceedingly intense. The mystic's description of his own experience, far from being futile, is indeed highly significant. According to the mystic's claim, the experience is transcendent; above intellect and above sense; in other words, purely emotional! * * * To a man whose ultimate goal is the acquisition of philosophic knowledge, but who has despaired of attaining that knowledge by ordinary lines of procedure, and who is in a condition of unhappiness and disappointment because of his failure, what is more natural than that in recalling the unusual and remarkable state of supreme satisfaction he should conclude that the joy was due to the attainment of that for which he had so long striven; since beyond that attainment he would ask no higher satisfaction? It is true that he cannot describe this illumination, he cannot even recall it; obviously, then, the knowledge was above description and above recollection."

"A universal characteristic of the mystic, which impels him to the mystic way, is a dissatisfaction with the scientific method and with scientific results. The mystic is essentially a tender-minded person who finds the hard labor and slow progression of science toward attainment of knowledge intolerably discouraging. Progress is so slow, and the goal so infinitely distant, that his soul 'melts within him.' It requires a high degree of hard-mindedness to be content with scientific progress, to bear the heavy weight of logic and intellectual clearness, and to be satisfied with the fact that the direction is right although the way is long." That Professor Dunlap means this literally, that he believes the mystic deliberately abandons the test tube to search for the third kind of knowledge, is shown by the following:

"The tender-minded person longingly raises his eyes from the rough and tiresome road of science to look with despair toward the (to him) uninspiring goal, and soon ceases to struggle onward. In desperation he seeks some short cut, some route which will be free from the handicaps and difficulties through which science finds its way; and, finding a route which promises ease, he eagerly accepts it. Oppressed, discouraged, despairing of the simple and easy solution of the problem of human life; realizing that the attainment of scientific knowledge is laborious and slow to the point of impossibility; conscious of his inability to make and keep the exact logical distinctions which the imperious goddess of reason demands, the scientific straggler welcomes the glowing dream in which, by waters of illusion, he is in possession of the simple satisfaction which the hard taskmistress, Science, has denied him."

If this were written exclusively to account for the presence of mysticism at the present day, when exploration in the field of the natural sciences is so popular, there might be some excuse for it. But did the mystic of a thousand years ago leave his laboratory experiments in weariness to seek the same knowledge in an emotional experience?

A much more important point is this: mysticism is not explained by calling it an emotion. This is merely pigeonholing the problem. It is not a common, everyday emotion and must have some specific cause. What is this cause? As to this Dunlap is silent. His only words are as to motives for the adoption of mysticism as a philosophy; there is not a syllable of explanation for the experience. This is the first example of what runs through the whole book—namely, an indifference to phenomena for which his formulations do not provide a happy explanation.

Having established mysticism as a type of philosophical thinking, he turns to the discussion of psychoanalysis. With a running comment of sarcasm and ridicule and with a joyous accentuation of the more extravagant statements and claims of some psychoanalysts, he nevertheless presents the basic elements of this new movement, and quite fairly he confines most of his argument to a consideration of these fundamentals. These are: that there is an unconscious mind having knowledge, ideas, and memories of which the normal personality has no awareness—this unconscious mind has its own awareness; "the most important of the ideas or furniture of the mind [i. e., the mind as a whole] are *desires,* which are instinctive productions of the human mind;" when these desires come into conflict with others of the personality, the former may be repressed into the unconscious and continue to reside there indefinitely; these repressed desires, theoretically, have suffered opposition on many grounds, but practically psychoanalysts find that the more important ones have to do with sex tendencies, particularly those of incest and homosexuality; these aberrant sex cravings originate in childhood; the unconscious repressed desires operate indirectly to produce neurotic symptoms, dreams, and many anomalies of behavior and thought in normal life; finally, symbolism plays a large rôle in the mechanisms of production of these phenomena. Mere mention of these claims is all that this review can attempt; adequate discussion would fill a volume, and it is presumed that the reader has already gained some familiarity with the literature of psychoanalysis.

A number of these claims Dunlap meets with flat denial or ridicule. We do not need to concern ourselves with such "arguments." He does attempt, however, to meet other psychoanalytic tenets with logical rebuttal, and these are the objections that we must consider.

Criticism is directed against the method of collecting evidence which he terms the "anecdotal" or "historical" method. This is the collection of observations made under circumstances that cannot be reproduced at will for experimental purposes. "The mere statement that such and such a thing happened in a particular case under certain circumstances is inconclusive because one can never be certain either that the description of the circumstances is sufficiently comprehensive—that is, that certain important details are not omitted from the account—or else that certain details specified in the account are not erroneously recollected." There can be no doubt that deductions drawn from experiment are more valid than those from observation of phenomena beyond our control, but research of the former order is confined to physical science in its narrowest sense. Had Dunlap paused to consider this, he would have realized that a large part of scientific investigation is concerned with the examination of processes continually in flux, where we can have little or no control of the factors involved. To take an extreme example, exclusion of the anecdotal method would eliminate from consideration Halley's observation of the comet that bears his name; in fact, all cometary observations would be open to this criticism. Except in so far as symptoms can be reproduced experimentally under hypnosis, all psychiatric material is anecdotal.

A corollary is more worthy of consideration. This method, Dunlap says, is peculiarly liable to the error of arbitrary inference. Certain data are selected for consideration and others neglected, the selection being made to suit a preconceived hypothesis. This is a valid objection; it is probable that the eccentric and exaggerated conclusions of many psychoanalytic writers are traceable to this source of error. Nevertheless, Dunlap has failed to take into consideration two factors. The first is that all the careful disciples of Freud test their interpretations, not only by their availability as explanations of the phenomena studied, but also by their conformation to general psychoanalytic principles. The latter inhibits arbitrary inference, although it introduces the factor of preconceived hypothesis. The preconceived hypothesis is in turn to be justified or rejected on the basis of the frequency with which the inferred explanation is found adequate to account for the phenomena. This is the method universally employed in biological science: all its conclusions must be tentative by reason of the nature of the material, and they become acceptable only when a large series of observations seems to confirm them. That psychoanalysis lends itself peculiarly to the fallacious reasoning of arbitrary inference is not ascribable to the method, but to the material and the deficiencies of many psychoanalysts. The second point neglected by Dunlap is this: he fails to realize that a fundamental working hypothesis of psychoanalysis is specific determinism of symptoms. For instance, he quotes from Freud the story of an accident in which a woman broke her leg. Freud so tells the circumstances as to make it appear that the woman unconsciously wished to have her leg injured and contrived the accident unwittingly. Dunlap rejects this because "the nervous excitement resulting in defective integration and faulty coördination could actually be causes of an accident." What Dunlap is talking of are predisposing causes; some kind of an accident is *liable to occur* in such a situation. Freud is here interested in the cause of the particular accident which *did happen.* Dunlap regards Freud's hypothesis as gratuitous because he fails to see the problem. Before the discovery by Koch of the tubercle bacillus, most physicians were content to look only for predisposing causes in pulmonary tuberculosis.

His most urgent and often repeated argument is against the concept of the unconscious mind. He reasons as follows: "Consciousness" has been used in many senses loosely, but should be confined rigorously to the process of *awareness;* biological processes accompanied by this awareness are psychological processes, others are physiological. As an example of what he means by "physiological," the following may be quoted:

"We do not, of course, suppose that what is forgotton still exists, in the same form as before, but stored in an 'unconscious warehouse' of the mind. An idea is not a thing like a written document which, after being in the active files, is taken out and stored in the transfer case. It is more like an act, such as snapping the fingers or striking a blow. I may snap my fingers ten times in succession; but no one supposes that the snaps have an individual existence afterwards and are somewhere stored away as snaps which are no longer snapping. No more does scientific psychology conceive of 'ideas' as something which can be stored away after they are through 'ideating.' In the one case as in the other, there is a physiological basis which is modified by the act in such a way that the act can be repeated at a future time."

To the unconscious mind, psychoanalysts ascribe functions that have conscious attributes and at the same time lack awareness. The hypothesis is therefore untenable. A few quotations exemplify this argument.

"Clearly in the Freudian system appears the fundamental anti-scientific postulate of mysticism: a form of knowledge—consciousness—which yet is not consciousness, something which, when it is convenient for the purposes of argument, can be given the attributes and qualities of consciousness, but which, when these attributes are inconvenient, is entirely divested of them. To this mystic knowledge in the Freudian system, as in that of philosophical mysticism, is ascribed an importance far above that of consciousness itself. The essential difference in the two theories is that whereas the philosophical mystics ascribe a purely intuitive value to ecstasy or union, the Freudians, in addition to the enormous intuitive importance—the unconscious includes a knowledge of all the experiences through which the race has passed—ascribe to it definite and practical physiological consequences. In comparison with philosophical mysticism, then, psychoanalysis stands out not so much as a mere variation on a theme as a gigantic expansion of it."

"The use of the mystic postulate, by removing the discussion from the galling restrictions of logic, makes explanation very easy. The standard psychoanalytic explanation of action and of consciousness alike is that they arise from the unconscious (or foreconscious or subconscious). If this term is taken in a definite sense, the explanation disappears, since it means nothing more than that the activities and the consciousness of human individuals are dependent on physiological processes; or else it means that the activities arise in consciousness, leaving the causes without explanation. To be more specific, an unconscious wish either is an unconscious physiological process, in which case it is not a wish; or else it really is a wish, in which case it is conscious."

In discussing an "analysis" by Jung of the conduct of a priest, Oegger, in a story by Anatole France, Dunlap remarks: "Assuming Jung to mean that Oegger's action was due to his unconscious wish to be a Judas, we may ask: did he have such a wish or did he not? If by 'wish' we mean something which we define from our own experience, Oegger either had a conscious wish or no wish at all. The Freudians' claim that there can be a wish that is not a wish is the making of a claim that there is something other than the wish of ordinary experience, which they will insist on calling nevertheless a wish; and which really has no connotation except the connotation derived from the wish of conscious experience."

"The false reasoning consequent on this use of an important term in two different significances is the well known logical *fallacy of ambiguous middle,* one of the devices most favored by all the great company of slipshod thinkers. By emphasizing now one meaning, now another meaning, of the term, dubious transitions may be made with ease, and a principle may be applied over a much wider range than exact logic would permit. If, as Jevons remarks, we argue that 'all metals are elements and brass is a metal; therefore, it is an element,' we should be using the middle term 'metal' in two different senses, in one of which it means the pure simple substances known to chemists as metals, and in the other, a mixture of metals commonly called metal in the arts, but known to chemists by the name 'alloy.' "

"The result of the fallacy of ambiguous middle as employed by the Freudian in such cases is that it gives a specious explanation, comforting to his demand for easy, but final knowledge, and relieving him of any tendency to seek for actual scientific explanation."

One may discern in all these quotations that Dunlap pays no attention whatever to the question of the presence or absence of phenomena on which the psychoanalytic hypothesis of unconscious activity is based. Nor does he discuss the inherent validity or uselessness of the concept of the unconscious from a general philosophical standpoint. What he does do is arbitrarily to define terms so that they make the concept illogical and impossible. One may in fairness criticize the use of terms as a matter of teminology or criticize the concepts represented by these terms. But to criticize the concepts on the basis of the terms is to descend to the type of reasoning employed by many savages who regard names and the objects named as identical. Psychoanalysts and Dunlap agree in delimiting "consciousness" to awareness. Dunlap says there is no other psychology, but only physiology. Psychoanalysts discuss what he terms "physiological" processes as being psychic in their nature. If they are right in ascribing strictly mental qualities to these processes, then the hypothesis of unconscious mental activity is tenable. The issue is one of fact, of evidence, not of "logic." If evidence can be adduced of ideas being present and taking part in intellectual operations which are beyond the awareness of the subject, then the psychoanalysts are justified in their assumption.[1] If this cannot be shown, then Dunlap's terminology is adequate and his argument redundant. The question of evidence he avoids by excluding the psychoanalysts' observations as "anectodal."

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[1] The evidence in favor of the hypothesis of the unconscious is of the same order as that supporting the theory of hormones in physiology. Most of these substances cannot be isolated, weighed, or chemically examined; they are known only by their effects, which are specific, although their origin in certain tissues may be demonstrable. If a physiologist were to argue like Dunlap, he might say, "Physiology deals with elements that have definite morphology or can be examined by chemical and physical means. Hormones cannot be so examined; therefore they do not exist."

Unfortunately for him, there is other evidence, not open to this criticism, as it is definitely experimental. Hypnotists have for decades reported phenomena which make the hypothesis of unconscious mentation inevitable. And Dunlap is not ignorant of this. He attempts to dispose of it in this footnote: "We are, moreover, not arguing against the possibility of real cases of 'divided personality,' to certain details of which Morton Prince has applied the term *co-conscious*. These cases must be examined, clinically, experimentally, and analytically, unprejudiced by Freudian or other theories of unconsciousness, and in the full light of the facts of integration, retention, and recall. Psychologists are not yet ready to make final conclusions concerning the mechanisms involved in these cases, and there is little use in dragging them into the present discussion. We may for the moment ignore their problems, as the Freudians have done." Now Morton Prince has some standing, so much so that, although he has given his life to a study of the "unconscious," Professor Dunlap dedicates his book to him. Prince has examined these cases precisely from the standpoints of integration, retention, and recall, and concludes that there are mental processes of which the subject is unaware. Both observations and conclusions have been published extensively. Apparently, however, observations are negligible unless made by the guild of psychologists. One would think that a scientist engaged in the discovery of truth would refrain from publishing such a book as this until evidence purporting to annihilate his theories could be examined by himself, if he could not trust the word of the man to whom his book is dedicated.

If his "fallacy of the ambiguous middle" were proved, the whole psychoanalytic system would fall to the ground and no more words would be necessary. But Dunlap keeps on protesting, and since logic is his plea, it may be worth while to examine his arguments. He speaks of the "unconscious" being a postulate. It never has been this, but always a hypothesis introduced to account for real or alleged facts. *His* categories of conscious psychology and all else physiology conform, however, to the definition of a postulate, closely if not completely. He frequently uses that facile argument to trap the unwary, the false analogy. The following is an example of this: "The things in Africa or the things of which I thought yesterday may exist or they may not exist to-day. If I am not thinking of them or perceiving them, they certainly are 'in the unconscious' (if they exist at all) in exactly the same sense as that in which the whole universe or those major parts of it of which I do not happen to be conscious are 'in my unconscious.' " It is amusing to note that immediately after his footnote about Morton Prince's work, he seems urged to indulge in his most illogical flights. The first is such an obvious confusion of his and the psychoanalysts' terms as to suggest that it is wilful: "It may be claimed that unconscious mental processes occur without our being aware of them. This is verbal quibbling, with a vengeance. The consciousness of which we are speaking is awareness: we are, so far, not concerned with any sort of mental processes than those in which consciousness occurs. In no case do we say that we are aware of the awareness; awareness is always awareness of something else. To say that we are aware of something and at the same time not aware of it is quite meaningless."

The second flight begins with the only fair statement of the psychoanalytic theory of the unconscious that he presents. This he demolishes by sliding gently from "unaware" to "unknown" and then "nonexistent," assuming that the reader will not notice the substitution of one synonym for the other:

"Sweeping aside the terminological confusion in which the believer in 'unconscious mental processes' commonly lurks, he might state his claim as follows: In addition to mental processes—i. e., organic processes involving consciousness (awareness)—there are other processes which, while they do not involve awareness, involve something which is more than mere physiological process: something resembling consciousness, but not conscious. This 'unconscious mental' factor is therefore an *x,* an unknown, and cannot be pointed out in any definite experience. [We presume he means that there is no awareness of it. Much alleged evidence of its effects he admits having read.] Such an hypothesis might be made. One might also hypothesize a *y* factor, a *z* factor, and an infinity of other factors, all equally unknown, equally beyond experience. But science does not indulge in the positing of hypothetical entities whose only qualification is that, they being unknown, we cannot know that they do not exist. Hypotheses which are by their nature removed from any possibility of verification are never constructed in science." What seems to us a fair analogy would be this: Let us assume that there is a force we will call *x* which would tend to draw an object to the ground; this *x* cannot be seen, touched, tasted, smelled, or heard. We might also hypothesize a *y* pulling it up, a *z* pushing it north, etc. *Y* and *z* can also not be perceived. All that we know about *y* and *z* is that they might exist, they might not. Science can't be bothered with them, therefore not with *x*. So there is no such thing as gravity. This is his "fallacy of the ambiguous middle" with no less than three middles!

These are his main arguments. His objections to the doctrine of "infantile sexuality" are briefly put and are summarized in the following quotations: ". . . . the child obviously has no sex desire in the true meaning of the term, although it may respond to sex stimulation." Again: "The Freudian hypothesis of infantile sex life is founded on the specific fallacy known to the logicians as the fallacy of *secundum quid.* Reactions which later become a part of the general sex activity are found in the child, and therefore pointed out as evidence of sex activity. It is as if one should claim that the labored breathing produced by running to catch a street car is *sexual* because the same labored breathing may occur during certain stages of sex activity. As a matter of fact, there is no form of activity and no form of instinct of the individual which is not at some time or other connected with the sex life, and the final consequence of the Freudian method is to define sex as *the whole universe,* which would leave us to hunt for a new term to use for what is meant by sex in science and common sense."

In these quotations it may be seen that Dunlap bases a flat denial on a difference of terminology, disputes the justice of the Freudians' using the term "sex" as they do, and ascribes to them claims more exaggerated than any they have ever made. As to the term sex as used of childish activities, many activities, auto-erotic and other, which contribute to the development of what is later sexual in the narrowest sense are called sexual by psychoanalysts *in so far as* they have characteristics peculiar to sexual strivings rather than to other physiological processes. If any one chose to call them "pre-sexual," psychoanalysts would not object. All they are interested in is the insistence on the sexual quality of such practices.

The chapter on psychoanalysis is concluded with statements about the bad effects of psychoanalysis on patients. With equal assurance he propounds his own theory: "I am convinced that the more important causes of neuroses are not to be found in ideas of sex, but rather in pathological sex activity." "A very frequent feature in the history of the male neurotic is irregular sex experience commencing often at a very early age." These experiences include actual incest, mutual masturbation, cunnilingus, and homosexuality! Morbid emotions accompanying these practices prevent satisfaction in the acts. Later in life the poor neurotic is upset by finding prostitutes unsatisfactory. As to this we may remark that the opinion of those who have seen a great deal of neurotics is that their sex life is freer from overt indulgence than that of their more normal fellows. How does Professor Dunlap learn in detail of psychoanalyses and of symptoms developing from them? How can a college professor, presumably attending to his teaching and laboratory work, who has never had a medical education and has never seen a patient except with a layman's eyes—how can he have collected material justifying such sweeping conclusions? Is this evidence "anecdotal" or is it, perhaps, just plain, vulgar gossip?

The last section of the book is devoted to a discussion of "the foundations of scientific psychology." In this chapter, the fact emerges that this is *his* discovery, and he finally expresses the belief that the majority of recognized psychologists in this country are merely "sympathetic" to his views. Since his logic has been so faulty as a critic, we are naturally curious to learn if his constructions avoid this error. He begins by laying down principles of method. There are five of these: (1) hypotheses must be based on fact; (2) working hypotheses must follow the law of parsimony—i. e., the simplest formulation that will cover all the phenomena must be adopted; (3) hypotheses must be tested by experiment; (4) verification of proof of hypotheses must be *scientific*—i. e., any one whose scientific training is adequate must be able to reproduce the results obtained by the discoverer when his experimental conditions are repeated (this excludes drawing conclusions from isolated events when conditions are not fully described or controllable); (5) terminology must be definite and unambiguous. These conditions do not seem complete, for under them the mystics might claim admission for their experiences and hypotheses, saying that any one who fulfills their conditions can have the experience. There should be a sixth condition: that new hypotheses should not conflict with well-established ones found to be valid in other fields of research. This is, in practice, what excludes the mystic's "third kind of knowledge" from scientific consideration. Its admission would overthrow the fundamental principles of natural science. On the other hand, as has been stated before, an insistence on experimental verification would eliminate from scientific examination all phenomena over which the examiner has no control. For instance, it would throw out all studies of consciousness (in so far as this refers to awareness of thought). No one can experiment with *my* consciousness. Its existence is proved only by my statement to that effect. A great many people say the same thing, but not all. Innumerable savages and most children up to the third and fourth year are without such consciousness. Perhaps the world over as many people believe in ghosts or have seen them as have consciousness of their thoughts. It seems, then, that in practice we rely in many scientific inquiries more on the reliability of the witness than on the possibility of experimentation.

Having laid down these laws, Dunlap proceeds to build up his hypotheses, beginning with "the biological conditions of consciousness." All his hypotheses are based on the "reaction-arc" theory. Briefly, this is that the central nervous system—including the involuntary nervous systems—consists of a mass of neurones. Some specialized ones are stimulated and send an afferent stimulus to other cells, which pass it on from cell to cell until finally there is an efferent current which stimulates muscular or gland activity. All the nerve cells taking part in this reaction constitute a reaction arc. It is not necessary to assume that consciousness is a function of specialized cells in the cerebrum, since the reaction-arc hypothesis accounts for consciousness and a great deal more. The function of the central nervous system is the production of responses—it is a kind of intricate switchboard and nothing else. Some reactions are accompanied by consciousness. "Consciousness (awareness) is the result of, or the accompaniment of, or a part of (the phrasing is for the present immaterial) certain reactions involving the activity of a complete arc from receptors to effectors. . . . . It is not necessary to assume that all reactions involve consciousness, but only that all consciousness depends on reaction."

This is so far rather pure tautology. There is no mention of what reactions are accompanied by consciousness or what the nature of the connection is between consciousness and the reaction arc. He might as well say: "Sometimes when the nervous system functions, there is consciousness."

His next hypothesis is not tautological: "Assuming that perception depends primarily on reactions which begin in special sense receptors, pass through the central nervous system to effectors, and terminate in the activity of these receptors, we still have to provide for the other form of consciousness—namely, thought or thinking. It has long been assumed that thought has 'motor power,' that activity is produced by thought, but this, according to our conception now, is a putting of the cart before the horse. Really, thought is dependent on, or a part of, a reaction; but where is the reaction initiated? Not in the cerebrum, for it has been demonstrated that there are no receptors there; and not, primarily at least, in any other part of the brain. For reasons which will be explained shortly, the thought reactions—that is, the complete reactions on which thought is dependent or which include or involve thought—must be assumed in most cases to be initiated in the receptors in the muscle spindles, in the striped muscles of the trunk, limbs, face, and vocal organs."

Here is a view which is open to experimentation, and accident or disease has frequently made the crucial experiment. If thought originates in muscle perceptions—and he evidently means this literally—then destruction of the muscles must abolish ideas. There are many nervous and muscular diseases in which muscle tissue disappears almost entirely. In these thinking is usually undisturbed. It is possible for an individual to live with his spinal cord divided in the neck so that there is no connection between the brain and any voluntary muscle except those of the head and neck and the diaphragm. Thinking is still possible and may be acute. In case it were urged that thoughts were initiated by the vocal, mouth, and neck muscles, it is easy to point to diseases where these are atrophied or have their nerve supply cut off from the brain. As a matter of fact, we know of only one disease where there is a disturbance of consciousness in regard to muscles when those muscles are paralyzed and this is in hysteria. It has been shown thousands of times, however, that in hysteria an idea of loss of function occurs first and the paralysis second.

As to emotions, he follows the James-Lange theory blindly, taking no note of the valid objections that have been directed against it.

"An emotion, or a feeling, is exactly a bodily condition—a real physical fact—which is perceived through the receptors in the viscera (and to a certain extent in the soma also) in the same way as that in which color is perceived through the receptors in the retina, or sound through the receptors in the cochlea of the ear. Put in terms of the reaction hypothesis, we say that the emotional reactions are initiated by receptors lying in the viscera (and in the soma) and that the reactions terminate in as wide a range of activities as do perceptual reactions generally."

His next discussion concerns the development of perceptions. He thinks the child is born with some of these—that, for instance, there are definite perceptions in connection with suckling, which is a volitional act. As to these alleged perceptions, we can have no direct evidence, since the new-born infant cannot tell us of them. The child's conduct can be explained without this assumption. As to the presence or absence of conscious volition, observation would tend to indicate that there is no effective wish to take nourishment, since the object sucked seems to be a matter of indifference. The mother always guides the child to the nipple at first. The tendency to restlessness and blind sucking when hunger is present is explicable as a purely reflex phenomenon.

Subsequent perceptions are built up as dictated by the laws of habit formation. His argument is based on the experiments of Pawlow, a typical one of which is described as follows: "If a dog, fasting long enough so that he will eat eagerly, is shown his customary food, or allowed to smell it, his saliva will commence to flow. If, at a time when no food is present, a bell is rung, there will ordinarily be little, if any, effect on the salivary secretion, although pricking up of the ears, or some similar action, may occur. If the dog, before being fed, is shown (or allowed to smell) food, and at the same time the bell is rung, and if this procedure is repeated on a number of successive days, an 'association' between the two reactions will be set up: that is, the arcs will become connected in the cerebrum, so that the ringing of the bell will produce the flow of saliva, without the food stimulus being required."

It may be well to pause here for a moment and examine the statement, "the arcs will become connected in the cerebrum." Unless the anatomic or chemical nature of this connection can be demonstrated, the statement is pure tautology and pure assumption. It is, moreover, an unnecessary assumption, for such phenomena can be intelligibly discussed in psychological terms as "associations." One may compare this with the hypothesis of an unconscious which facilitates the discussion of mental phenomena and hence has pragmatic value.

He proceeds: "Obviously, the two reaction arcs which were at first somewhat independent—the arc from the olfactory receptors (assuming the food to have been smelled, and not seen) to the salivary glands, and the arc from the auditory receptors to (let us say) the ear muscles—have become connected in the cerebrum so that the current flowing in over the afferent part of the one may now flow out over the efferent part of the other: or, as we say, one discharge may be drained into the other. This particular aspect of integration which we generalize as *drainage,* and which is experimentally verified, we find will apply to and explain all habit formation, including both the development of perception and the association of ideas."

"Let us suppose that the visual presentation of an orange, to a child of a certain age, is merely color. The consciousness of the color depends on the activity of a certain reaction arc which we will call V—v: V being the receptor activity, and v the terminal effector activity. Let us suppose that the child smells the orange peel also, is allowed to taste the juice and grasp the orange in his hand. We may represent the olfactory reaction by O—o, the gustatory by G—g, the tactual by T—t."

"If two or more of these reactions occur simultaneously, or in immediate succession, and this is repeated, so that eventually each reaction has occurred a sufficient number of times with each of the others, we will have the conditions established for integration of the same sort as that occurring in the experiment on the dog, described above. The several reaction circuits become connected (in the cerebrum) so that the afferent current from any of the four senses represented may flow out over any of the original efferent routes. In other words, stimulations of one sense, as for example vision, may produce the effects formerly produced by stimulation of one of the other senses—or may produce, in a measure, the effects of all. The child eventually, from the visual stimulation alone, perceives, not color merely, but the orange, as a round, yellow, odorous, heavy body with sweet juice."

"Manifestly, the development of perception is more complicated than the scheme here presented, because other perceptions are also being formed, and they mutually modify each other. With the consolidation (integration) of the reaction arcs also goes modification of the terminal muscular activities; and in many cases these activities, at first movements of the whole body, become modified into words—standardized reactions of the complex system of vocal muscles. The illustration given above is nevertheless typical, in spite of its simplification."

There is in this argument a most serious lapse of logic. Pawlow's experiments show "drainage" of energy (or stimulus) from the afferent part of one reaction arc to the efferent part of another. By analogy to this, in the case of the child with the orange, sight of the yellow orange might produce muscular movements of handling, tasting, etc., but if there were perceptions of heaviness, sweetness, etc., called forth, there would be drainage from the afferent part of one arc to the afferent parts of others and not from afferent of one to efferent of another. For this drainage from afferent to afferent, he offers no evidence whatever and so far as the reviewer knows there is none. In other words, the reaction-arc hypothesis has not yet solved the problem of compound perceptions. The hypothesis of words being specialized motor responses does not fall under this criticism, of course, and one could say that complicated perceptions are secondary to word formation, being merely awareness of unspoken words. This, however, would involve the psychologist in the belief that complicated perceptions did not exist until language was established, although there is much evidence to the contrary.

His discussion of the association of ideas seems again to be a translation from psychological into physiological terms. He begins by describing association of ideas as habits and then proceeds: "The association of ideas is, from its description, *manifestly* a species of habit formation and should conform to its general laws." [The italics are the reviewer's.] This is waiving a large part of the problem at once. Only the most superficial study of free association limits the phenomena observed to associations of the habitual. Many are, apparently, quite unexpected and might be explained as *unconscious* habit, perhaps, but not as due to habits such as Dunlap describes. Moreover, the associations of the same individual may be markedly different at different times, although beginning with the same stimulus. He proceeds from this postulated identity of habit with association of ideas as follows:

"If ideas are dependent on reactions, and if ideas are capable of association, it must be that the ideational reaction arcs are of such a nature that the completion of one reaction may initiate another. Since reaction arcs terminate in muscles and in glands, it must be that in one of these tissues lie the necessary receptors of the thought arcs. The receptors in glands are as yet conjectural, and the glandular response is not of such nature that we could assume it to be the stimulus of reactions as prompt, as manifold, and as finely graded as thought reactions apparently are. The striped muscles, however, are provided with a plentitude of receptors in the 'muscle spindles,' and the muscular responses are quick, finely graded, and of great complexity, competent to initiate reactions of an endless variety. The muscle receptors are, therefore, in all probability, the beginnings of the thought arcs.

"If we assume the muscular initiation of thought reactions, the mechanism of the association of ideas is at once clear, and it is also identified as the mechanism of habit formation of a much wider range. Whenever a series of reactions is knit together so that eventually the series repeats itself if given the proper start; the muscle contractions are primarily the connecting links, each set of contractions being the terminus of one reaction and the stimulus for the next. The association of ideas is just one instance of this general type of habit formation."

The same formula will then cover either a habit of consecutive muscle movements or ideas. The mechanism is this: a reaction arc A terminates in a muscular movement a. This contraction provides a stimulus a′ to the muscle spindles of the muscle involved; a′ is a receptor impulse which, if habitually associated in point of time with a reaction arc, may be drained off into the effector response of B, just as with Pawlow's dog the ringing of a bell led to secretion of saliva. Similiarly B may lead to C and so on. This ingenious formula, applicable at once to both physiological and psychological processes, depends, of course, on the assumption that mental phenomena can be expressed in physiological terms (a question to be discussed shortly) and on the adequacy and validity of the muscle-spindle-idea hypothesis. The latter we have seen to be untenable on grounds of clinical—i. e., experimental—evidence. But supposing that this objection could not be made, we would still be faced with a hypothesis consisting merely of a description of mental events in physiological terms. Since these particular reaction arcs (the ones resulting in mental functions) have never been studied physiologically, this translation into physiological terms is pure tautology.

The relationship of integration to attention is his next topic. In the human animal the various reaction arcs are integrated so that a unitary function is achieved. "In other words, every stimulus influences all the reactions of the organism, and every motor activity is determined by the total stimulation playing on the receptional system." The phenomena of attention, long looked upon as a specific and detached mental function, is thus explained: "The more efficient an animal's reaction to a single source of stimulation, the more completely must its nervous system be integrated at the moment of reaction into a single system of reaction arcs, in which the analytic arc from the receptors affected by the stimulation in question, to the most characteristic movements in the response, dominates the whole system." This conclusion is a natural corollary of his earlier arguments and is equally tautological.

He follows this with a most suggestive speculation as to the origin of consciousness: "The facts concerning attention, and its dependence on the degree of integration, furnish us with an interesting suggestion towards the solution of the problem of the relation of consciousness to neuro-muscular action. We have found that consciousness depends, not on the action of individual neurons, but on the joint action, in a reaction arc, of a functionally related group of cells. We see now that the more complex the system of cells acting together, the higher the degree of consciousness. These two details taken together suggest that mere reaction alone is not a sufficient condition for consciousness any more than mere neuron activity is. Some degree of absorption of the reaction (integration of the arcs) into the total system of reactions is indicated as the lowest condition of consciousness, and complete dominance of the system as the possible upper limit. On this supposition it would be clear that the isolated knee jerk and kindred 'physiological' reflexes could not be expected to be conscious, although attendant and consequent reactions may be conscious."

Now, in consequence of the researches of Sherrington and Head and their pupils, reaction arcs are fully established as existing on the physiological level. That they should furnish the ultimate basis for mental reactions is not unlikely. The question is, at what point of integration do physiological reactions begin to assume mental qualities? Dunlap suggests that a reaction becomes mental when its arc is integrated with the integrative whole. ("Mental" and "conscious" are identical terms by his definition.) Since attention is, in his view, only a hyperacuity of consciousness, an adaptation of the integrative whole to a single reaction or group of reactions, there must be, as he says, all gradations of the process. In other words, there are reaction arcs integrated within the integrative whole, and thereby affecting the reactions of the whole, which do not demand that subjugation of the whole to this reaction which is the prerequisite of attention and consciousness. These reactions are, then, qualitatively like conscious ones and differ only in a quantitative way. The quality they possess is integration with the whole and this, according to Dunlap, is consciousness. Such reactions have, then, qualities of consciousness and at the same time have no consciousness. This is precisely the sense in which psychiatrists use the term "unconscious."

The final pages of the volume contain nothing new, being merely generalizations repeated from the previous discussions with the same attacks on psychoanalysis.

There remains to be discussed a most important point, one that lies at the very root of scientific method. Dunlap, in attempting to account for mental phenomena on the reaction-arc hypothesis, has been accused of tautological translation of psychological into physiological terms, a process for which Adolf Meyer has coined the excellent phrase "neurologizing tautology." The matter cannot be allowed to rest there, for one might suppose that he had simply failed in pursuing what might be a profitable method. It is a popular line of research and speculation among psychologists, this effort to analyze mental phenomena into non-mental elements. Tichener goes so far as to say that the object of the science of psychology is to eliminate the "mind." Is such a thing theoretically possible? Quite flatly it is not, and the error lying back of these efforts is responsible for an incalculable amount of worthless "scientific" work.

One of the most fundamental principles in the natural sciences is that when units or elements are combined or integrated, new properties or functions appear. In fact, the proof of combination rather than mixture comes from the new characteristics. For instance, a solid metal, sodium, combines with a gas, chlorine, to form a salt, known as sodium chloride. This salt is a crystal. Does this crystallization come from the sodium or the chlorine? From neither, but from their combination. This crystallization cannot be described or discussed in terms of the properties of either sodium or chlorine. It can only be discussed in crystallographic terms. It is true that sodium chloride can be broken up into sodium and chlorine and that this salt has properties ascribable to the presence in it of those elements, but when these sodium and chlorine properties are eliminated, there remains the crystallization quite unaccounted for. Similarly, if the salt be put into water, a solution results which has innumerable characteristics in addition to those represented by the symbols H_2O and $NaCl$. Solutions in turn have their laws which are independent, *qua* solutions, of their ingredients. Hence chemistry is divided into physical chemistry and analytic chemistry. Analysis continued until doomsday would never teach a chemist anything about solutions, except what elements were there. If he analyzed brine, he would find hydrogen, oxygen, sodium, and chlorine, all of which discoveries would be valuable, but they would teach him nothing about the boiling point, surface tension, freezing point, electrical conductivity, or optical properties of brine. To study these, he must accept brine as a solution and study it by the methods of physical chemistry. If, perchance, a chemist examines a substance all of whose properties are explicable as the sum of the properties of the elements into which it is analyzed, then it is held, *ipso facto,* to be a mixture, not a synthesis.

Let us advance into the biological field. Chemical analyses show the presence in the body of carbon, calcium, sulphur, nitrogen, oxygen, hydrogen, and so on. Their properties do not account for physiological reactions. They are, however, combined into elaborate compounds, some of which have been synthesized outside of the body. Yet the sum of the properties of these complicated compounds accounts only for a few very simple and relatively insignificant physiological reactions. Oxidation of hydrogen and carbon is a relatively simple matter, yet the phenomena of respiration in all its ramifications cannot be fully accounted for by any laws which physical science offers or can offer. The methods of physics and chemistry tell us the analytic combination of nucleoproteins and the temperature at which a germ cell divides; anatomists describe the chromosomes, and patient observation has even shown that sex is linked with an odd or even chromosome; yet all this gives no answer to the question, why does it grow? The capacity for growth and reproduction is a biological property. The question will never be answered in any but biological terms. Even if chemists should succeed in synthesizing proteins and fabricating a living cell, the question would not be answerable in chemical terms, for the created properties would be a product of the synthesis—a biological compound—and not of the elements, any more than the properties of solutions are inherent in water and salt. Even after this prodigious feat were performed, we would have to continue to discuss biological phenomena in biological terms.

Finally we come to specialized biological functions which are termed psychological. These are again products of synthesis, of integrations that have produced new phenomena, not predictable from the nature of any of the combined physiological elements. Physiological methods will teach us much about the factors underlying mentation and essential to it, but physiology can teach us nothing about the mind *as such.* Not that physiology is without value to psychology. Far from it! Without physiology we would not know that the nervous system had anything to do with mental functions; we might allocate them to the heart or even to the surrounding atmosphere. Imagine a physical chemist ignorant of analytic chemistry and you would have a picture of what the psychologist would be without the aid of physiology.

The inevitable conclusion from this reasoning is that we must have the physiologist to teach us what essential elements are requisite for the initiation of mentation, but the psychological phenomena must be investigated as such and described in psychological terms alone. The effect of translating psychology into physiology is, therefore, not merely idle, but actually pernicious. How much would we know of heredity and embryology to-day if biologists examined ova and sperm cells by chemical means alone and did not observe their reactions *as* ova and sperm cells?

In conclusion, one may ask why Professor Dunlap—and other psychologists—feel impelled to fabricate these unprofitable hypotheses. There are (at least) two answers. The first is that one effect of the growth in importance of natural science has been to give most people the conviction that somehow chemistry will solve the problems of biology and biology dispel the mysteries of psychology. This belief partakes of the nature of religion or superstition in the proper sense of these terms. So strong is this belief that few scientists are without it. With many it is an overt article of faith, while with a few it is merely an unacknowledged motive. The second reason is more specific. The school of psychology in which these workers were trained dealt with psychology as a branch of metaphysics or as an experimental study of the physiology of the special senses and of the simpler intellectual functions, such as memory, attention, etc. This training leaves one unprepared to examine or understand that large mass of phenomena which have been studied by psychiatrists during the last twenty or thirty years. These phenomena have to do mainly with instinctive and emotional life. The psychiatrists have had no more training than the psychologists—in fact, not so much, as is evidenced by their deplorable terminology—but they have at least gone honestly to work to collect facts and speculate about them in mental terms. The academic psychologist, on the other hand, has been faced with a delimma: he had either to admit ignorance and incapacity or to avoid the issue. Professor Dunlap is one of those who has chosen the latter way out. He has fabricated a scheme of psychology that leaves to the psychologist only the study of what he knows about—consciousness. All else is "physiology." It is not necessary for him to know any physiology[1] as that is not his profession. But is the physiologist prepared to explain to us the nature of instinct and emotion and their operation in our lives?

Professor Dunlap repeatedly states that psychoanalysts turn to the hypothesis of a "mystic" unconscious because they cannot face the ardors of scientific labor. Is his case much better when he disposes of phenomena that will not fit into his system by handing them over to a hypothetical "physiology" that cannot explain them? The temptation to conclude with his last sentence and some comments on it is too strong to be withstood: "Upon all of the profession I urge the consideration of the serious nature of the present situation, and the necessity of uniting on the solid ground of scientific method for the defense of public welfare against charlatans and teachers of superstition. . . ." The tendency to fall back on what is, essentially, a "third kind of knowledge" is an inveterate habit of mind which accounts for much confusion in scientific work. Few schools are without it. There is much proof thereof in psychoanalytic work, if Dunlap knew enough to find it; he has chosen the wrong examples. But if only each student would try to set his own house in order before meddling with his neighbors, we would have no polemics because trespass would be unknown. There would then be no tendency for workers in one field to usurp another of which they are ignorant. Only the urgent nature of the present situation forces us to accept the challenge thrown down by Professor Dunlap—and others—and to undertake an examination of the principles on which his "science" is built. It were much better if this inquiry could be made by the psychologists themselves.

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[1] In a footnote on p. 97 Dunlap exhibits complete ignorance of the evidence on which the "all or none" law in physiology is based. Since this law has applicability to some psychological problems, the error is serious.

AN EMOTIONAL CRISIS

A Description and Analysis of an Episode that Occurred Among Psychopathic Women*

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THERE is a great opportunity, we believe, for physicians, and particularly for neurologists and psychiatrists, to help in solving the problem of psychopathic delinquent individuals in general and especially that of the psychopathic delinquent woman. The recent investigation at the Bedford Reformatory has brought the latter problem with renewed emphasis before the public, and those who have had experience with it in the past are frequently asked what the real situation is. The purpose of this paper is to describe an episode of an extreme emotional nature that occurred among a small group of psychopathic delinquent women, in order that those who are not dealing intimately with the problem may have some idea of the kind of difficulties that arise wherever such women are confined in institutions, even under the most favorable conditions possible.

When the Psychopathic Hospital of the Laboratory of Social Hygiene at Bedford Hills was opened, an attempt was made to treat the patients as nearly as possible as is usual in a psychopathic hospital not connected with a reformatory institution. All unnecessary sources of irritation were removed and each patient was helped to make the individual adjustments that are necessary in any social group. Besides facilities for hydrotherapeutic treatment in the form of continuous baths and wet packs, there was an occupational department, the usual resources of domestic training, a department of physical training, a goodly amount of recreation, and a staff of nurses who, besides their general hospital training, had had special training in the treatment of mental patients. At the time the incident to be described occurred, there were but fourteen women in the hospital, which was equipped to accommodate twenty. This number included patients and workers, the latter being some of the more stable reformatory girls on whom we were dependent for the housework. None of the punitive measures usually practiced in reformatories was used, except in the occasional locking of doors when individual patients became so much disturbed that they upset the equilibrium of the entire hospital if allowed to mingle with the others; or when it was necessary to control superfluous visiting, which may become very undesirable among these women whose sex emotions seek outlet temporarily in excessive affection for one another.

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* Read in part before the New York Neurological Society, May, 1920.

The *dramatis personæ* of the emotional episode or crisis, as we have called it, were, first, Margaret, an English girl of seventeen, the leading character in the drama. She was considered an epileptic. The diagnosis was always obscure as she not infrequently brought about attacks that were hysterical in nature, as, for instance, when she was to receive gynecological or antiluetic treatments or when she was to have a lumbar puncture. At such times she would inform us that she would have an attack if we proceeded. She was always able to accomplish it, even to the extent of apparent unconsciousness. Occasionally she had attacks of unconsciousness suggesting epileptic seizures, but without typical convulsion. Her personality, however, strongly suggested the epileptic make-up. She was extremely egotistic, wished to rule any environment in which she was placed, resented authority in any form, worked hard at times, but always spasmodically, was extremely irritable, restless, and quarrelsome, and was generally unreliable, having little loyalty for those who did the most for her and of whom she was most fond. The psychological tests showed that she had normal intelligence. Her intelligence quotient was 80. She had been sent to the reformatory on a charge of petit larceny.

Second, Sophie, a Jewish girl of twenty-four, who was of the manic-depressive reaction type. While somewhat hypomanic at that time, she was not considered sufficiently abnormal to be transferred to a hospital for the insane. She gave a history of two previous depressions. Very careful nursing and tactful management were required, moreover, to prevent her from being affected by the other members of such an inflammable group. Because she had been in the hospital since its beginning, she had a sense of ownership regarding it and a feeling of superiority over the others which were not altogether welcomed by them. She was considered a border-line case intellectually. Her intelligence quotient was 64. Her offense was grand larceny.

Third, Florence, another Jewish girl, twenty-five years old. She was classified as a psychopathic personality. She was a "shut-in" type and was exceedingly sensitive. The fact that she was deaf tended to increase her sensitiveness. She also gave a history of a depression lasting two years—from the age of fifteen to seventeen—during which time she remained in the house, talked very little, and showed a particular aversion to men of her own race. While she was in the hospital, she kept much by herself and occasionally had attacks of excitement lasting a day or two, during which she was depressed, exceedingly irritable, and unable to do work of any kind. She also had phobias of various kinds—of fire, of the ceiling falling on her, etc. The psychological tests showed her to have normal intelligence. Her intelligence quotient was 98. Her offense was prostitution.

Fourth, Anna, a large Norwegian girl of nineteen, classed as a psychopathic personality, with a superabundance of energy associated with much childishness. For several years before she entered the institution, Anna had refused treatment for lues. One wondered how many strong men would be needed to control the situation should this young Amazon some day carry out her various threats. The tests of her intelligence placed her in the class of "dull normals," her intelligence quotient being 74. She was sent to the reformatory because of her refusal to receive treatment for her physical condition.

Fifth, Amy, an American girl of eighteen, with fair bobbed hair, who looked far too young to be with women in a reformatory of this kind. She was also of the cyclothymic type of personality, and although exceedingly unstable emotionally and usually somewhat hypomanic, she was kind-hearted and light-hearted, brimming over with fun and with unstinted energy. She never let anything get by her and was an integral part of everything that was going on. Amy could have had a good education in a quiet New England town, but she could not stand its quiet and came instead to a small town in New York, where she worked in a factory and sought out the worst companions that were available, having been found in chop-suey houses by the police before she was sent to Bedford. Her intelligence was considered normal, her intelligence quotient being 80. Her offense was prostitution.

The crisis itself might be described as a general emotional riot resulting chiefly in screaming, with much oratory of a profane and abusive nature, that began about nine o'clock in the evening, reached its height about eleven, and continued in all its intensity and without respite until half past two in the morning. There was no destruction of furniture and no windows were broken, although how they escaped it is difficult to say. There was no violence shown against any nurse or matron, and fortunately we were able to keep a locked door between the deadly antagonists, Margaret and Sophie. It was Margaret, the epileptic, however, who may be considered the chief cause of the disturbance. When she entered the reformatory, she had a traumatic vulval lesion associated with which was evidently a recent Neisser infection and an initial luetic lesion. She became hysterical when a vaginal examination was attempted.

When she was admitted to the hospital, she found that no coercion was used in the form of punishment and that the girls were taking a certain pride in maintaining a fairly good standard of conduct without it. Being uncoöperative was at least frowned upon. To join in with this spirit meant that she would be one among others, and it meant also that she would have to accept authority and submit to the gynecological and antiluetic treatments that she dreaded and intended to escape. The alternative seemed to lie in defiance of authority. And, moreover, if she stirred up trouble among the other patients, it would at least give her a compensatory sense of power as their leader. This she proceeded to do, the horrible fear of the treatments furnishing additional energy for her endeavors.

She would show them. She was not going to be treated. They could be foolish if they would, but not she. They would see. Gradually an atmosphere of dissatisfaction developed in the group, which was not too contented at best. Although much was being done for them, it was never enough. They wanted more. They were sick of this damn' joint. They wanted to go home, etc. Just about this time a teacher of gymnastics who had charge of the outdoor sports and of their recreational activities left voluntarily because she could no longer stand the strain. The girls told her they would have a riot if she left them. Before she left, however, they had given a short play. The effort and tension necessary for such a performance, however simple, almost invariably result in such a group as this in an undesirable reaction. This time was no exception. Moreover, many quarrels that had started had been postponed until after the performance. On the day following the play, while they were all somewhat elated and before the teacher left, an emotional wave swept over the group. This lasted for several hours during the afternoon and consisted of an excited argument screamed on the sleeping porch so loudly that the neighboring cottage could hear everything said. The immediate issue was an implied partiality on the part of a nurse toward Margaret, our epileptic, who was laughing loudly and disturbing the others who were supposed to be resting. The situation was difficult to manage, as Sophie, Florence, and Amy refused to leave the porch, determined to stay and see that no partiality was shown. No amount of persuasion had any effect, and we did not use force. A very critical situation was developing. Margaret was about to hit the trail. Having started a spirit of revolt and mutiny, she saw a chance to slip in on the crest of the wave in the tide of restlessness she had been influential in causing, win favor in the eyes of the staff, and again be a leader, this time of an uplift campaign rather than of the opposition.

This emotional wave quieted down somewhat by night. There were, however, four prominent factors in the persistent restlessness of the days that followed: first, the excitement resulting from the play; second, resentment because the play leader was about to leave; third, the mutinous spirit of discontent that had been engendered by the epileptic patient; and fourth, and probably strongest of all, the growing resentment against the epileptic herself, who had at first said such uncomplimentary things about the hospital and its staff and now was in a fair way to become "teacher's pet." What they thought of her treachery, as they considered it, could not easily be expressed in words or forgiven. And, on the other hand, the staff, after weeks of struggling against her antisocial attitude, could hardly fail to encourage her effort to change.

When asked if she did not think something could be done by the girls themselves to improve things, she said, "Something must be done, for I simply can't stand this any longer, and I'm sure I'll willingly do all I can to help." This frank conversion, this hitting the trail, of the most antisocial member of the group was too much for the others to stand. That this girl, who had used the most insulting names possible in speaking of those in charge of the hospital—particularly one term which, as one of them said, "no one had ever used before"—should suddenly desert them and march off with flying colors roused the depths of their resentment. Their attitude—perhaps influenced also by the restlessness of Amy, who had been more unstable than usual since the first afternoon of excitement—was that of demanding all the favors that they could think of and showing extreme resentment when these, however unreasonable, were denied.

At supper on Sunday night—the night of the real crisis, several days after the sleeping-porch incident—there was so much noise in the dining room that Margaret, the epileptic, spoke up and requested that they be quiet or they would all have to suffer. That was the last straw. There was a roar of resentment at Margaret as the source of this suggestion, which was only partly quieted. Early in the evening, two girls were heard to say on different occasions, "I am going to raise hell to-night." Realizing the extreme tension that existed, the staff made every effort to tide over the situation and prevent its reaching a climax. Although an outbreak was averted while the girls were together in the recreation room, their energy, pent up for several weeks, broke forth after they were in their rooms.

Sophie had attempted several times during the day to assert her authority and gain the prestige which she felt was due her because she had been in the hospital since its opening. During the afternoon she had been very much depressed and talked about the disgrace that she had brought on her family. Later she became disturbed because a girl whom she had considered a protégé was accused of playing another patient "dirty."

Margaret, who was suffering with menstrual pain, was crying softly in her room, while Sophie continued to laugh and scoff at her, making insinuations about her to Fanny, the colored girl, who was across the corridor. The noise became so loud that it was necessary to close the transoms above the doors. Sophie's transom was closed first, and then Margaret's. Sophie, believing that Margaret's had been left open, immediately accused the nurse of partiality for closing her transom and leaving "that thing's" open. Although she was told that both were shut, she would not believe it and began pounding on the door with her hands and shoes, calling Margaret all kinds of names and continuing to accuse the doctors and nurses of partiality. Finally, when Margaret could stand it no longer, she screamed to Sophie to shut up, seized her water pitcher, and said she would smash her window if her transom were not opened. Realizing her determination and appreciating her potentialities, we opened her transom. By this time Sophie, who had been in an exceedingly unstable condition for days, had become quite maniacal and began to call Margaret the most insulting names she knew. Margaret, who had stood the concerted hatred of the whole hospital as long as she could, suddenly gave vent to her wrath and, shouting out the worst names she could, demanded that her door be opened so that she could get out and wipe up the floor with the other girls. She, too, became very much excited, throwing herself on the floor, then on the bed, moving her furniture about, slamming her window up and down, tearing her hair, and screaming constantly in the most penetrating manner. When the nurse opened the door to talk to her and remove breakable furniture, she threw a glass against the door, breaking it, and ordered away every one who ventured near the door, saying that she wished to be left alone. Then there followed at the top of her voice the most bitter tirade imaginable against the race to which

Sophie belonged. Even though the windows were closed, her voice could be heard at a great distance.

In the meantime Sophie was screaming with equal anger and vehemence, answering each attack made on her race and personality. Florence, because at this time she was much under the influence of Sophie, and because she, too, resented each remark that Margaret made against her race, began to bang at her door, demanding loudly to be let out, stating that she must see what was going on, and at the same time with a whining voice saying that she must see that her friends, especially Sophie, had fair play.

As Margaret's eloquence continued, the insults that she had stood in the last few days from other patients came to her memory and each in turn was brought into her screaming speech. "I ask you, do they pick on Fanny? No, they don't. Why don't they? Because they know that she won't stand for it and will give them what they deserve if they attempt it." Whereupon Fanny, whose room was directly across the hall, would, in loud and no uncertain terms, tell Margaret what she thought of her, calling her "two-faced" and so forth. Fanny's language had no limitations in its frank expression. She, too, demanded to be let out, and promised to "do up" Margaret at the very first opportunity, warning her to stay in her room if she valued her life.

Anna, whose room was on the corridor below, whenever her name was brought into the speech, banged on her door violently and threatened to break all the furniture in her room if she were not let out immediately; so that the only alternative seemed to be to unlock her door and reason with her. Reason, however, was of no avail, and she immediately mounted the stairs to the upper corridor and walked back and forth like a caged animal in front of Margaret's door, frequently adding her arguments to the others' and threatening violence to Margaret if she could get hold of her. Amy, not to be left on the lower corridor when all the excitement was above, followed Anna's example and by the same method managed to get her door open and join the group in the hall.

The hospital was built to accommodate a pleasant family group and there was only one room in which noise could be even faintly lessened if a single patient were disturbed.

Adjoining this, however, was the continuous bath, which was a little removed from the main corridor. It was finally possible to get Sophie into this room, and the attempt was made to persuade her to get into the tub. This, however, was not successful, as she was only too anxious to get back into the center of the fray.

In such excitements as these, when taking a patient anywhere against her will, it is always advisable to lock the other patients into their rooms. Under the present circumstances, however, such procedure was difficult, with Amy and Anna rampant in the hall, insisting that their presence was necessary in order that fair play should prevail.

It will probably be difficult for any one who has not had actual experience with such excitements to appreciate what this bedlam was really like that began a little before nine o'clock Sunday night and lasted until nearly three o'clock the next morning, with no cessation or alleviation whatever. It may be of interest to add that the hospital was of fireproof construction and even the slightest sound made in the building fairly reverberated through it.

Inasmuch as our cottage offered no possibility of separating members of the group, each girl continued to react on the others to a disastrous degree, and whenever it was possible to quiet a single individual for a short time, some one was sure to excite her a little later and start another tide of emotion that it was impossible to quell. The excitement was too general for the use of packs, and those who needed them most could not be persuaded to take prolonged baths. Furthermore, on this particular evening the hot-water supply was low!

After several hours Sophie promised to be quiet if allowed to return from the continuous bath to her room. Although it was doubtful whether she would be able to be quiet, the experiment was tried, but as soon as she was again on the corridor, the previous conditions were resumed. Margaret was then removed and placed in the operating room at the other end of the hospital, where a cot was put up temporarily for her and where she promised to make no further disturbance. Sophie, finding that Margaret had gone toward the "quiet room," wished to ascertain just where she was and get near her again; so, after having refused steadily for two hours to take a continuous bath, she now demanded it in order to get near her opponent. As it was thought that the bath would be of some benefit to her, and that Margaret, although in the same part of the hospital, would remain quiet, Sophie was again taken to the continuous bath. She had no real desire for it, however, and complaining that the water was too cold—it was actually a little under the prescribed temperature—she demanded again to return to her room. Her maniacal condition did not abate, and she remained in the corridor in spite of all protests until between two and three in the morning, again enumerating her troubles from beginning to end and heaping abuse on her sworn enemy and on the staff. It was not until three o'clock in the morning that any degree of quiet descended on the hospital and the two girls on the lower corridor could be persuaded to go to their rooms.

Realizing that in such a small building it was impossible to separate the group sufficiently to get control of the situation permanently, we decided to keep some of the patients in their rooms the next morning. Consequently Fanny, who was the laundress, was the only one of the women described who was allowed to go to work, and Amy and Anna, among others, were told to remain in their rooms and rest. This they resented tremendously, and as we had been fairly certain that this would happen, we had arranged in the meantime for the removal of one, and perhaps both, to another building.

Anna battered on her door and threatened to break all her furniture if she were not allowed to come out into the hall. Amy, as was to be expected from her suggestibility, immediately followed suit and demanded that her door also be unlocked. As the other patients were at breakfast and the noise was becoming exceedingly upsetting to those who had already lived through the horrors of the preceding night, and as we realized that Amy was soon to be removed, she was allowed to come out of her room to get a broom which she demanded. As she went down the hall in full view of all the patients in the dining room, she picked up a chair and sent it spinning the length of the corridor with an air of great bravado. Fortunately the furniture of the hospital had been chosen with such emergencies in view, and the chair showed no ill effects from its journey.

Possibly the most dramatic point of the whole crisis was the docility with which Amy and Anna responded to the order of the disciplinary officer who arrived from the reformatory a few minutes later. With an air of great deference, Anna said, "Will you excuse me one minute while I get my handkerchief?" It was briefly explained that her handkerchief would not be necessary, and she followed the disciplinary officer meekly. These two patients, however, were disturbed to such an extent that it was many days, even in a new environment, before they reached anything like a normal level. Sophie, whose deepest complexes had been touched during the crisis, continued to be disturbed over a long period and was finally transferred to a hospital for mental disease during an acute maniacal attack.

Margaret made considerable noise on the following evening, but gradually became more quiet as the days went on. Until Sophie left the hospital, however, to be transferred to a hospital for mental disease, the fire continued to smolder. One was never sure that another outburst would not occur, in spite of the fact that they were kept apart almost entirely, and although Sophie had a special nurse most of the time from that time on. Margaret continued to be a difficult case in the hospital, but, although she occasionally resorted to screaming as a defense against unpleasant treatment, she gained in control and for periods of one or two weeks at a time was able to do consecutive and always well-executed work.

Amy, after a leave of absence of several months, returned to the hospital at her own request, having wept bitterly at being taken out. While she still showed much emotional instability, she showed also a sincere effort to take responsibility and adapt herself to her environment.

Fanny, the colored girl, who had been in the hospital for a number of months in the capacity of a worker rather than as a patient, was soon after this transferred to the main institution. She had been sent to the workhouse when twelve years old, because she gave her age falsely, and she stated, probably truthfully, "What I didn't already know I learned there."

Florence had periods of depression in which she was much disturbed. These gradually increased until, during a prolonged attack, she became hallucinated and was transferred to a hospital for mental disease.

In studying the etiology of this emotional crisis, one is confronted with the fact that there were elemental factors in its make-up that were mental, physical, and social, all so intimately bound together that it is hard to separate them from one another. It might be well, however, to examine the stage and its setting, which was so well prepared before the curtain rose and the drama began. For the stage setting was composed of elements that may be considered quite apart from the important factors that caused the crisis itself.

First of all, there was Margaret's very difficult personality, seeking, with the characteristics of Kipling's walking delegate, to stir up a spirit of antagonism in the group in order to gain prestige and to avoid the situation that, because of her hysterical characteristics and her physical condition, was such a hard one for her to face. Second, there was the girls' rage at her desertion of the cause she had so valiantly supported and their disgust at her newly acquired uplift tendency, which was being so disastrous in its back-fire on them. Third, there was the excitement that always follows the production of a play in such a group as this, and, fourth, the loss of the favorite teacher, which, with their childish natures, they resented so much.

The implied partiality of the nurse toward Margaret, and the girls' virtuous demands for fair play during the emotional wave that occurred on the sleeping porch and represented the prologue to the crisis, were in truth but excuses for the preliminary explosion of the seething emotion resulting from the four factors of the stage setting already described.

The curtain rose at last on the real drama, an anlysis of which shows a number of more or less distinct elements in its make-up. The first of these is the notable emotional instability of the entire group, even in the absence of frank mental disease and defect, associated with exceedingly little inhibitory power. The various mental abnormalities found may be described under the general heading of psychopathia, with perhaps the manic-depressive and schizophrenic trends and the basis of epilepsy already mentioned. Added to this were many exaggerated characteristics of personality, such as extreme sensitiveness, often coupled with aggressiveness, over-activity, over-suggestibility, poor judgment, suspiciousness, defiance, sullenness, and combativeness. Whatever their deeper significance, all of these traits of character, common though they may be to both normal and abnormal people, in their intermediate stage in psychopathic personalities are oftentimes the most obvious cause of the maladjustments of such individuals and constitute the outstanding features of their emotional explosions.

Briefly stated, then, the emotional instability of the group as a whole, plus the abnormal mental trends and the exaggerated traits of character, constitute the most important factors of the drama.

Another factor that stands out with such prominence that it seems necessary to describe it under a separate heading, even though it may be the expression of abnormal trends or of undeveloped personalities, is the extreme immaturity of the entire group. Prior to the episode described, this was evidenced by their lack of appreciation of anything that was done for them and by their incessant demands for the impossible; and during the prologue and the drama, by their general immaturity of judgment, which freed them from any feeling of responsibility of a constructive sort and allowed them to assume unwarranted responsibility for their comrades that could be of no service; and, furthermore, by their exaggerated resentment of correction of any kind. This last characteristic is associated with the antisocial attitude common to many of the women which has resulted only too often in a failure to make adequate adaptation to authority. Their habit of life has been, in most instances, to evade authority in every form—first parental, later as expressed in the school, and, later still, by the law; and they have continually attempted to get the best of every one with whom they have come in contact. The attraction of such women for members of the same sex, their exhibitionism, their auto-erotic tendencies, and their unsocialized egotism may be considered an expression of the fixation of their personality development at infantile levels.

Again, all of the characteristics that we have described as evidences of childishness may be considered attempts at compensation by an ego that has failed to express itself constructively at home, in the school, and in the community. Such manifestations might be considered more basically as socially unconstructive expressions of the instinct of self-preservation.

The third factor in the drama may be found in the strong elemental instincts that seek unhampered expression in the lives of these women. Whether this, too, is the result of mental instability or expresses an imbalance in the psychobiological development of their personalities, it is, perhaps, difficult to determine. This factor was evidenced by the expression of love, hate, anger, and jealousy in pure culture and with much abandon. In the lives of many of these women it frequently seems to be the overpowering urge of elemental instinct that has made it impossible for them to maintain their balance and has precipitated them into the social situations that have resulted in their being sent to reformatories. During their residence in the reformatory, the same elemental urge expresses itself in infatuations for their companions and particularly for colored girls, who appear to be a temporary substitute for the masculine companionship that is being denied them. Fanny's overwhelming popularity suggests the expression of this condition.

The fourth factor of the crisis, and the one that in our estimation constitutes the main difference between the emotional group episodes that occur in reformatories and the excitements that occur in hospitals for mental disease, is the expression of the herd instinct. In the hospital for mental disease, each patient is absorbed by his individual difficulties; in the reformatory, on the contrary, the group may combine with concerted action on the slightest pretext against an individual, against a group, or against authority. One sees evidence of this in the attitude of the group toward the newcomer. They are invariably suspicious of her until they have tried her out and feel that she can be trusted with their secrets. Their cruelty is extreme if they think she will "rat" on them. Episodes of a so-called hysterical nature, such as are seen throughout history—the burning of the martyrs, the punishments for witchcraft, the lynchings in the South—have undoubtedly been in part an expression of the herd instinct.

In this episode there was an additional element of racial feeling that further exaggerated the tendency already present to band together against the enemy. This seems to indicate a close relationship between the herd instinct and the instinct of race preservation. Perhaps the fury and emotion evident in the manifestations of the instinct of the herd may be explained by its close relationship to the instinct for the preservation of the race, which is already recognized as the source of much of our strongest emotion. The factor of suggestibility already mentioned as a characteristic of the personalities of many of the individuals of this group is doubtless an influence that accentuates the expression of the herd instinct.

A fifth factor, which should at least be mentioned, is that of the physical elements that played their part in the scene. The greatest irritability in nervous patients, as is well known, is frequently seen in connection with the menstrual period. This would account for Margaret's excessive irritability at the time, which was of course an element of the greatest importance in the emotional wave.

One might wonder if, in a group of this kind, established sex habits that were not having outlet should not be considered a cause of irritation and restlessness. In the present instance, however, this factor could be ruled out to a great extent since the majority of markedly disturbed cases in the group had had very little sex experience.

The sixth and perhaps the most significant factor in causing the extreme intensity of the situation, once it was started, was the individual complexes that were aroused in two of the patients. Sophie had said months before that she was troubled over something that she would reveal to no one. During the acute maniacal attack that preceded her transfer later on to a hospital for mental disease, she told us that she had married a Gentile by whom she had had a child. After living unhappily with him for a year and a half, she left him.

She did not know where he was or whether the child was still alive. She had never spoken of this, and even her own family was ignorant of it. An epithet applied to her on the night of the crisis had been used by her husband in one of their most emotional scenes to express his contempt of her. This brought vividly to her mind the part of her life that had been the cause of her greatest suffering and was associated with her most intense emotions. The cause of the attack was doubtless the stirring up of the emotional levels that she was trying so hard to repress.

Margaret also had deep emotional levels which she was unwilling to have tapped and which were related likewise to the factor of race. Her enmity for Sophie recalled her hatred of her stepfather, who belonged to the same race. She had been devoted to him and jealous of her mother, as she sometimes admitted frankly and also described to us unwittingly in her dreams. At the height of her emotional outburst, she informed us that it was because of her stepfather that she had finally left home and taken the step that resulted in all of her troubles.

If such an episode as we have described were indigenous to the soil of our psychopathic hospital, there might be reason to think it the result of our leniency. But its counterpart is only too familiar to those who have dealt with the same class of women under a variety of circumstances, and might be considered a mild outburst when compared with the riotous times that even at the present time are not infrequent in similar institutions and in which the participants appear to hold lightly human life itself.

The treatment of the psychopathic delinquent woman involves the rehabilitation of the entire individual. To this end as many resources as possible should be made available. These resources may be briefly summarized under the four headings: therapy, education, social organization, and discipline.[1]

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[1] We believe that had some system been in use in which there was a definite deprivation of privileges for unsocial behavior, and had such a system been administered from a therapeutic rather than from a punitive standpoint, there would never have arisen the extreme situation here described. After the experiment of

Therapy should comprise treatment of both a physical and a mental nature. There should be the equipment of a general hospital as well as of a psychopathic hospital, that there may be facilities for establishing the best possible physical and nervous foundation for a mental and social reconstruction.

The educational resources should include instruction in clerical, industrial, domestic, and out-door occupations, as well as in ordinary school subjects, in order to furnish opportunities for stimulating individual interests and to supply incentives for their development.

The social resources should include an organization that would encourage the best institutional spirit possible, whether it be obtained through an honor system or through some modified form of self-government. Very important in the social scheme are the recreational activities, which should be sufficient in number to be constructive, but never demoralizing.

The discipline—which we believe to be indispensable, both from the standpoint of the individual and that of his management—should serve to maintain as high a standard of conduct as possible in the institution and to increase the efficacy of the whole program of treatment.

The solution of this very intricate problem will never be found, we believe, in therapy alone, in education alone, in self-government alone, or in discipline alone. The best chance of its solution lies in the utilization of all these resources by those who have the greatest knowledge of human behavior. It is because of their experience with human conduct in many of its deviations from normality that neurologists and psychiatrists are urged to contribute their efforts toward solving what is, perhaps, the most difficult of all social problems.

pure therapy had been tried for a period of seven or eight months, a disciplinary matron was installed who had had success for years in dealing with the most difficult women in the institution. She worked in conjunction with the physician, helping the women to make adjustments that the physician found advisable for each individual patient. She deprived the patients of privileges when necessary, but always as a therapeutic rather than a punitive measure, and with the knowledge and consent of the physician. While the management of the hospital did not become an easy one even with the support of such a disciplinary backbone, still there was much less friction than before, and the patients were able to accomplish far more in a constructive way than ever had been possible under the old régime.

MENTAL HYGIENE AND THE COLLEGE STUDENT*

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PHYSICAL health cannot be an end in itself. We would seem to lose sight of this at times, although we tacitly admit it at all times in our failure to esteem highly those about us whose only claim to distinction is an exceptional physical prowess. Physical health can only be a means to an end. Longevity can scarcely be that end, for longevity of itself can be of no importance—it is the quality of a life that counts. The end we all probably have in mind as the chief justification of our work is that in increasing health we are making possible an increase of individual happiness and efficiency; and by efficiency we no doubt mean not, narrowly, economic or industrial efficiency, but ability in meeting personal problems of whatever nature. But happiness and efficiency are but partially dependent upon physical health. Of all the unhappinesses that you and I may have had during the year that is now just closing, how precious few of them have had their source in ill health! How many of our failures and inefficiencies, little and great, can we honestly say were due in any large part to poor physical condition? Or how much happier do you conceive we would have been, or how much more efficient, had our physical health been tenfold better?

I do not, of course, minimize the importance of physical health. Had serious epidemics been abroad in the land, or had our physical health, because of ignorance or indifference or carelessness, been not what it was, our unhappiness during the past year would have been increased many times and our efficiency greatly lessened. I would merely point out that if our goal in public-health work is essentially to increase human happiness and efficiency in a positive way, we are likely to miss that goal if we act upon the belief that it is to be attained through physical agencies alone, and continue to ignore the fact that happiness and efficiency are essentially dependent upon mental factors.

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* Read before the American Student's Health Association, Chicago, December 31, 1920.

Colleges and universities have been slow to recognize in any practical way the importance of physical hygiene, although the fact that this meeting is possible is evidence that faculties are beginning to see that it may be worth while to look after the health of students while those students are yet well. It is extraordinary, however, that universities whose function it is to work with the minds of students should still attend so little to the mental health of those students, although reasons for this neglect may not, after all, be so difficult to find.

If some have felt that happiness was dependent upon physical health, there have been others who have felt that happiness was dependent upon intellectual development. Educational systems have been built largely upon this assumption—train the intellect and school the will that they may rule over the "baser animal parts." It is upon this that schools and universities have been engaged. Intellects have been trained in great number, and the result in increase of knowledge has been very large. A child in the grade school of to-day has more information than had Aristotle. But with it all we find ourselves little nearer the goal. Much as it may injure our self-esteem to admit it, we are forced to doubt that happiness and efficiency are rooted in intellect. It fills us with pride to think that our lives are controlled and directed by the forces of our intellects—thus as humans we are different from the animals. Unlike the animals, when faced with a difficult problem, we gather together our bits of information and apply cold reason to the formation of our judgment. Although each of us occasionally may wish that we had a little more "brains" to apply in making a judgment, we are quite sure that it is the "brains" (intellect) we have that are applied. But we largely fool ourselves. If we will ground our pride, I think we will find that all too often our decisions are quite largely made before our intellects come very fully into play, and that our intellectual processes perform the function largely of finding reasons to justify the already made decision. In other words, our decision has been made upon an emotional basis rather than upon an intellectual one; the control and direction of our lives lies here, and what we each need is not alone more "brains," but a larger conscious control of what "brains" we have. If intellect controlled our destinies, most of the great problems of the day could be very soon settled; but, as we know all too well, intellect, in its relation to these problems, is largely used for balancing, countering, and compromising conflicting emotions. We know, also, quite well that this is equally true in the problems of our individual lives. The application of the "dry light of reason" alone would soon resolve most of our problems, but this dry light has a limited opportunity, for few, if any, of the fundamental and controlling interests of our lives and the problems that arise from them are alone intellectual.

There are other reasons why universities have been indifferent to the mental health of their students. Mental ill health has meant to them mental deficiency (feeblemindedness) or mental disease (insanity), and of the former there is none to be found in universities and of the latter only an occasional case. Mental hygiene, therefore, cannot be an important problem for them. This, however, is a misconception. Mental hygiene as a movement has had to concern itself very largely with the problem of the care and treatment of the great body of helpless sufferers ill of frank mental disease and with the social and economic problems that develop about them; but mental hygiene as a department of medicine is vastly more concerned with the mental health, the happiness, and the efficiency of the average normal person, of you and of me, of our wives and our children and our neighbors.

Then, too, mental hygiene seems a vague and intangible thing. It is still surrounded in the minds of many with superstition and mystery. A cat may look at a king and we no longer call it lese majesty; we may admit a belief in the science of modern biology and not be termed sacrilegious. Both terms have largely lost their force to-day, but the noisomeness and fearfulness that once surrounded them have not gone out of the world, and if we refuse a worshipful attitude towards intellect and turn our attention towards emotions, while the once fearful words will not be applied, much that once went to make those words fearful is likely to settle about. Men fear most, of course, that of which they know least. We may feel safe in speaking of intellect—moral connotations have been stripped away; we may even glow with pride in speaking of will—the will has always been a moral agent; but the emotions have always been a "poor relation," and not only a "poor relation," but a "poor relation" that has done time in the workhouse, whose ancestors were all bad. Men in his line have been hung for murder, and it is reported that they have not always had a proper attitude towards women. He is animallike and low, and, if we cannot deny him, we can make a pretense of ignoring him. This will at least help us to differentiate ourselves from his bestial line.

Except for contagious diseases, the lack of helpful information is probably no greater in the field of mental and nervous disease than it is in any other field of medicine; and ignorance, as an excuse for fear, is no more justified here than elsewhere. Let us for a moment look into the situation of the college student to see, first, if the problem of ill health is one that we need be concerned about, and, second, if there exists a body of knowledge that may be of help. Let us review some of the immediate problems with which the college student finds himself confronted, the tools he has at hand with which to meet these problems, the solutions he is likely to discover in using such tools, and the possible consequences of those solutions.

Decisions for the first time rest with him. He has been quite ready to make decisions for some time and has frequently been piqued that more liberty has not been given him in this regard. Decisions, he figures, are easy to make. One needs merely to know exactly what one wants and to move directly towards it. There will be slight distractions, to be sure, but with a clear purpose and a will to succeed, there should be no real difficulty. One must distinguish sharply between right and wrong. The counsel one has received in one's youth need not, to be sure, be the final word, for times change. In the newer situations one must use one's own judgment, but there are certain fundamental principles that should be adhered to. These principles are largely axiomatic, are world-old, and, therefore, are to be depended upon. One should be honest with one's self and with others. This should really not be very difficult. One should be sure of one's motives. One must credit others with equally good motives. It is probably true that there are people who are not honorable, who cannot be wholly trusted; but the number is probably not nearly so large as has been supposed, particularly among educated people. If one is fair and straightforward, others will be equally fair and straightforward. One should be frank, friendly, and generous. And one must be open-minded. One must not be easily discouraged. There are bound to be periods of discouragement and failure, of course, but one can always learn from one's failures and make them stepping-stones to better things. The thing will be to find out just why one has failed and see to it that it doesn't happen again. Thus courageously, if naïvely, the student starts out to add to his store of knowledge, and, in all good faith, to prepare himself to make the world a "better place because he has lived in it."

Somewhat to his surprise, he soon finds that he is not called upon to meet the larger issues he was prepared for. There seem to be no moral dragons to slay. It is all so much simpler than he expected. As he had rather suspected, his friends at home have been oversolicitous; but that, of course, is natural, for it is impossible for them to know what college life is to-day, and they have never fully understood him or had the confidence in him that he has deserved. One wishes one might be tested a bit more, that more important issues might be at stake. The problems one meets are petty and unimportant, merely troublesome, such as the distribution of one's time. How much should one "bone"? There is, of course, more to college than just books. One should mingle with one's fellows; one must have recreation; and one should be interested in athletics, even if one does not take part. One should be a supporter of all that is best in college life. How soon should one begin to specialize? Is one justified in giving more time to a subject in which one is particularly interested and for which one has a bent—as, for example, literature—or should one school one's self by forcing one's self to give time to a subject for which one does not seem particularly adapted, as, for example, mathematics?

Is it really dishonest to falsify one's monthly expense account? If a true account is given, it is likely to make the folks at home a bit unhappy; but when things are really all right, is one justified in causing this unhappiness, when it is due not to the situation, but to a misunderstanding of the situation?

There are so many odds and ends of things hanging about undone. How does he happen to forget these things? How did they get done at home? He cannot remember that he was even very much aware of them before. None of them is important, but collectively they are annoying and troublesome. One should have system and organization, but all his systems seem to get too complicated and his organization is always being upset by extraneous circumstances.

Without knowing it, he misses affectionate attention and, restless, goes about looking for something he cannot find. He finds himself but one in a crowd, and there arise the problems of mingling with the crowd, of losing one's identity in order to find it; the problem of making and keeping friends, adapting himself to fraternity or other group relationships. Gradually philosophical doubts or social and economic doubts begin to assail him, and he finds himself afloat on a sea of troubles. Anxious and concerned, he throws out anchors of axiomatic truths that had been forged for him, but they drag or snap. If he does not lose entirely and from thence on float about a dangerous derelict, he will likely find eventually quieter waters, but with the marks of his combat deep upon him. Permeating the entire situation, there will be not one, but several, sex problems to bother him.

As the student in the midst of his new complexities begins to take account of himself, what does he find? Although he has always been rather pleased with his self-assurance and ability to meet and mingle with others, he may find himself surprisingly awkward and embarrassed in the crowd. He has always enjoyed the society of others, has been, in fact, more or less of a leader at home; but now he finds himself filled with a strange self-consciousness and an embarrassment in trying to express himself. In fact, he does not express himself, not his real self. His new acquaintances, he is sure, are getting quite a wrong impression of him. They think he is inclined to be fresh when he has no desire to be fresh; or they think his ideas and opinions are unimportant when he knows they have value. He is sure he is better than a good many of those about him, but some seem to be getting the idea that he need not be considered. He is sure they are not getting his true measure. He is surprised at a lack of facility for making friends. He does not wish to be a hail fellow well met, but he would give a good deal to be able to learn to know people as readily as some of the others do. He knows he is capable of very deep friendship. He has a high ideal of friendship—nothing is more real than a true friend; there is nothing he would not do for a friend. But no one seems particularly interested in having him for a friend. How does one go about making friends? He is very much attracted to people who seem quite indifferent to him. When he joined the fraternity—or when, with a group, he decided to stay out—he thought this problem was solved, for he never liked a group of fellows more, particularly the older men—was there ever such a fine lot? And to be not only a friend, but a brother to these men! But now, as things have settled down for the year, they do not seem to pay much attention to him. In fact, some have been quite disagreeable. He does not seem to fit in.

He has an opportunity to compare himself with others, such as he has never had before, and the comparison is not always in his favor. In his former small group he may have shone as an unusually good student; or he may have had facility for some particular subject, so that he excelled. Here he finds that there is nothing exceptional about him at all. In fact, most of the students in his classes have as good minds as he, and many far outclass him. Indeed his ability seems quite ordinary. He no longer takes pride in any special facility—there are quite too many who are far cleverer than he, in what he thought was his own field. From this and from other comparisons, he becomes aware of what he believes to be an inferiority. This may be increased in the gymnasium, where he may find that his physical development does not compare well with that of others—he was not aware of this before; he had considered himself as sturdy and as well-developed as the average fellow. But this reminds him of some habits of his, and he recalls how, upon starting this new life among men, he was going to be through with those habits. It would somehow be easier; in fact, it would be quite easy. But he hasn't changed; he is just as rotten as he ever was. No wonder he looks like a wart beside these fellows. How disgusted they would be if they really knew! Of course, manly chaps like these have never had such habits. They are men of strong will. He is different and really hasn't any right to be around them.

But if he finds himself inferior, he is generous enough to be glad that there are real men in the world—men of brains, men of integrity, and men of strong will. He finds them about him. He places them upon pedestals, glories in them unselfishly, and in his humble way tries to be worthy of them. And all too soon he finds his heroes have hideous feet of clay. In the classroom he may find both intellectual and emotional stimulus. Warmed by the enthusiastic discussion of a professor in classroom, he seeks him out in the quiet of his study, for he has seen a light and must know more of this. What he expects to find he himself probably does not know, but vaguely there is a feeling that professors who glow in the classroom glow at all times. He finds the professor more or less just human and probably a bit bored. In his shock and disappointment, he puts him down as considerable of a faker —as an actor who has no real interest in his subject, but who for classroom effect screws himself into an emotional enthusiasm he does not feel.

He finds himself strangely moody at times. Neither especially happy nor sad, but stirred by a vague discontent and restlessness. Spice and zest seem to have gone out of things. He is indisposed—he is probably just lazy, he thinks. Or things may take quite another turn and instead of vagueness there may be unaccountable floods of emotion that pass over him and puzzle him. But whether the puzzlement is from one source or from another, he finds his attention distracted and work becoming more and more difficult.

He is distressed by a strange new attitude he finds developing toward his family. He has come to the time when emancipation from the family, the breaking of bonds that hitherto have held and limited him, is necessary. But he does not know this except vaguely. He knows that the family bothers him; he wishes they would let him alone. They mean well, but they do not understand either him or his problems. In fact, they never have. What are relatives anyway? After all, why should one "love" one's parents? One's parents are a fortuitous circumstance. One has a right to one's own individuality, and the development of individuality may demand getting rid of all fortuitous baggage and assembling about one's self those things and those people who best express or best call out the larger things in one's personality. At any rate, "love" and "affection" cannot be commanded. If he doesn't "love" them, he doesn't "love" them, and that is the end of it. It cannot be helped.

This new attitude shows itself, although it remains unexpressed, in many ways to those at home. The situation is likely misunderstood, and the boy begins to receive letters of complaint and upbraiding for his neglect of home, for his infrequent and unsatisfactory letters; father writes and says that the boy is making mother very unhappy.

In boisterousness and a bit of rioting, perhaps, the boy covers his feelings, but he is exceedingly unhappy. Books are neglected, for in the solitude of his room his thoughts gnaw at him. Extravagant diversions give him relief. Is he really a rotter, he wonders. He recalls now with some satisfaction what at the time he refused to admit—that earlier in the year he was a bit homesick. He ought to feel sorry that he has hurt his mother, and in a way he does and in a way he doesn't. Is he becoming incapable of affection? He hates silly sentiment, but is he capable of nothing more? At least he might be loyal to those who have been loyal to him. He might pretend an affection; but that would be grossly dishonest and dishonorable. But is anything more rottenly dishonorable than not to feel a sense of obligation to those to whom one is really obligated? It's all a confused mess. Through misunderstanding and consequent bad handling of the situation at home and through the growing strength of the boy's own biologic urge for independence, the breach grows. Although a fairly satisfactory compromise will likely be found eventually, the boy will gain his first steps in emancipation at a price in unhappiness, loss of time, and of efficiency that should not have been paid.

From the many emotional problems with which adolescence is faced in any place, but more particularly in college—the losing and finding of one's self in the crowd, the making of friends, the comparisons, physical, intellectual, social, that are forced upon one, the assimilation of new knowledge and points of view, the deciding of courses and principles of actions—I have selected a few. I may not have been happy in my selection, but I have tried to choose the most simple ones, those that are quite upon the surface and in more or less full consciousness, and have been careful to avoid the more complicated problems that lie essentially in the unconscious field, even though these are more significant, and more important in their consequences. I have much over-simplified the account, but let us see where even this very simple and obvious account leads us. Have these rather commonplace stresses and strains any significance?

You will probably say not. There is nothing unusual about these experiences. They are more or less the experiences of every student. It is these things that make the man out of the boy; there is probably nothing more valuable in the whole of the boy's college life. We have all been through it. None of us has experienced any particular harm from it, and we can now even look back with considerable amusement at the turbulency of those days.

A boy becomes a man by the mere physical process of living a certain number of years. The quality of his manhood and his effectiveness, however, is quite another thing. If you still believe that all children must have measles and that the sooner they have them, the better, then you will see only good in this process. If you believe there may be serious after effects of measles that it is well to avoid, then you may be willing to consider possible after effects in some of these situations. Or, if you are one of those who believe that the best way to teach a boy to swim is to throw him unassisted into water over his head, you will thoroughly approve the present method of letting the boy sink or swim in another situation.

There is not one of us but has his psychic scars of this period. There is probably not one of us but would like to be more efficient, more forceful; would like to see his problems more clearly; to make his work more sharp-cut and direct; to keep to his plan with less distraction; to maintain a better perspective; to gain a closer coöperation with others; to be more successful in presenting his point of view to colleagues; to win greater confidence; to have a larger faith in his own integrity. All sorts of reasons we assign for our failures, and mostly they are intellectual. When it comes down to it, we simply haven't the brains. It does not seem to occur to us that we may not have the full use of the brains we have. I question if it is the quantity or quality of our intellects that hinders us. I am inclined to think it is our emotions we stumble over—our prejudices, our antagonisms, our strong likes and dislikes that catapult us into judgments that we must later find reasons for defending; our habits of thought and stereotyped methods of reacting; our undercurrent of cynicism, perhaps (in spite of the fact that we thoroughly dislike cynicism), or our too constant and ill-founded optimism, or our false pessimism (false, because we do not intend to be pessimistic, and yet we seem to react pessimistically before we know it); our too great placidity, perhaps, or our touchy irritability; our surprising intolerance, when we pride ourselves on breadth of view; our astonishing lack of generosity, when we wish to be generous; our disconcerting tendency towards disingenuousness, when we wish to be frank; the little intellectual dishonesties we slip into almost unaware, when we believe such things beneath contempt. And yet we are reasonably successful men. No one—and least of all do we ourselves—feel that there is anything mentally wrong with us. The difference, however, between ourselves and our less successful colleagues or between ourselves and those for whose failures we erect hospitals is largely a difference of degree.

It is not possible here to describe in any completeness the various ways in which the college student may react to his unusually stimulating environment or to trace to their source the various mental habits, helpful and otherwise, he is likely to acquire in his unaided effort to understand both himself and his environment and to find some sort of acceptable compromise between them, but we may select a few for discussion, again the more simple and obvious, and from them judge somewhat of the significance of the whole.

What way he will take depends, of course, upon a good many circumstances—very much upon the mental habits he has formed earlier, somewhat upon his native ability or the congenital quality of his nervous system, to a certain extent upon his physical health and the acuity of his intellect. None of these things, however, even at best, will give more than an added buoyancy to his craft. None is more than an assurance.

He may find his way out quite successfully. He may develop a faculty for analyzing situations with an almost uncanny skill. He may learn to meet his problems frankly and to find a direct way through them. He may be so fortunate as to find some wise person who will help him. But even if this be not so, he may come through even as you and I—sufficiently well to deceive the world most of the time and ourselves at least part of the time and to win a not uncreditable amount of success in productiveness, efficiency, and helpfulness—but with our distinct handicaps.

He may fail entirely. The confident youth of October may by January be a quite disconsolate youth. He is full of worries (a symptom, not a disease); his sleep is badly disturbed; his appetite is gone; he is unable to study, he knows he is going to fail. This adds to the worries, and the vicious circle is confirmed. He has distressing headaches; his eyes bother him; food nauseates him; or he has cramps and diarrhoea or he is constipated; he feels weak all over; it is almost impossible to get up in the morning and, when once up, it takes a mighty effort to get himself about. He likely has his own idea of what is the matter—he has ruined himself with his disgusting habits, the very habits he has been "warned" against. This is not a thing he can see a physician about. He may pack up and go home, a self-confessed failure. He may struggle on until the faculty send him home at the end of the semester. He may consult a physician, who, finding nothing wrong with his eyes or his stomach, may dismiss him. If he confides in the physician his own fears, he may find help and assurance if the physician is one who has come to conceive all anatomical parts as equally human; while he may have his worse fears confirmed if the physician is one who is still able to distinguish in man's anatomy both human and animal parts.[1]

From every university and college there drop out as failures each year a considerable number of young men and young women. The faculty have felt assured that they have not had the intellectual ability to get on and have asked them to go. A sense of failure is thereby added to their already exaggerated feeling of inferiority, and they enter upon their way in the world with a handicap from which they may never succeed in freeing themselves. It is not to be doubted that students do occasionally get into college who are not sufficiently equipped intellectually for college tasks, but a proper investigation will show beyond any question that in a large number of cases the intellectual ability has been quite sufficient, but that, enmeshed in a complex trap of emotions, from which in many instances they might quite easily have been extricated, these students have been unable to utilize what intellect they had. The university, with its interest narrowly focused upon the intellect instead of upon the mind as a whole, has seen the failure, but has not been interested in carefully investigating the cause or in protecting against it. It would be just as reasonable to neglect a student who had broken his leg and, when gangrene had set in, to expell him for not attending his classes. But the boy with a broken leg is not neglected; every possible skilled attention is given him, for the university can see that the broken leg is no reflection upon the boy's intellect—the intellect will still be worth training after the bones are knit. But the boy who is wrestling with a crisis in his emotions is left to struggle alone, although the consequences may be far more serious, and, when his difficulties have got the best of him, is cast out as unfit. If faculties were composed of those who believe that broken legs and appendicitis are "errors," it would be reasonable of them to demand that the boy with a broken leg correct his "error" and attend his classrooms, or depart. But, although broken legs are tangible, concrete things in the view of faculties and to call them "errors" is ridiculous, these same faculties would seem to see no absurdity in considering emotional difficulties "errors."

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[1] I have emphasized here the problem of masturbation because it is so frequently a source of difficulty; but it is to be remembered that even in those cases where it seems to play the major rôle, it is not the complete account; although an important element, it is but one of a number of elements in the situation; at best masturbation is but a symptom. Neither is it safe, in cases such as that outlined above, to jump to the conclusion that masturbation is an essential element.

A larger number of students than is supposed develop, as a result of their experience and its neglect, frank mental disease (insanities); others stumble out of the schools only to be picked up and tended a few years later. A very much larger number develop crippling and incapacitating neuroses. Scattered between the two extremes, however—those who successfully find their way through and those who develop frank illness—comes the large body of students, each with his own particular warp. Some are very considerably warped and will recruit the world's supply of college-graduate failures and mediocrities. We may review briefly this group in the making.

In any college group there will be found those who are beginning to edge away from the crowd. This edging away should not be confused with a later adult desire to simplify one's life, to get away from the distractions of manifold duties, the "continuousness of discontinuities," where one can think and plan in peace and quiet. The adolescent group of which I speak withdraws, not deliberately in order to think and to solve problems, but instinctively, perhaps, we may say, in order to avoid pain. It is the beginning of a withering-up process, as of a plant too long in the direct heat of the sun, and leads to various degrees of incapacity, from the dementia-praecox patient in the hospital, content with his own autistic thinking, to the ineffectual day-dreamer on the outside. Up to now, the student has healthfully been putting out pseudopods, as it were, feeling out and absorbing from his environment; but he begins to find his environment too complex. In whatever direction he puts out a pseudopod, he finds not food, but nettles; reality has become too painful; pseudopods become less frequent; he begins to roll up in a ball and to find contentment in a world of his own construction; the less that world is checked up with reality, the greater the contentment.

Others, to the same general situation, react a bit differently. Day-dreaming and fantasy building fill up their lives. Not the day-dreams that are inspirational means to ends more real than reality, the dreams that make the world go round, but dreams that are an end in themselves, for they are hitched to no dynamo. These students glow with fine emotions and are frequently the joy of their instructor, because of their quick appreciation of the finer sentiments and ideals he is trying to express. Later he records these students as "disappointments," but with no sense, probably, of personal or university responsibility, or of opportunity neglected, of succor withheld because the need was unrecognized. To him, in all likelihood, the matter is an unfathonable matter of fate, much as he may still consider infant mortality—"The Lord giveth and the Lord taketh away. Blessed be the name of the Lord."

If a keen sense of reality and the habit of constantly correcting one's thinking by reference to reality is necessary in the development of the steadfastness and clearness essential to mental health, so, too, is intellectual honesty; and yet in any college group may be seen the development of contrary habits. An easy expedient in meeting a disagreeable situation, for example, an unattainable desire, is to deny the desire and to minimize the value of the thing wished for. The wish is genuine, nevertheless, and assuming a false attitude merely makes it much harder to meet any later situation in which the wish comes and should be realized.

Emotional difficulties may be met by rationalizing them, a process whereby one succeeds (only partially) in deceiving one's self, although quite frequently others by assigning for a course of action a reason that is not the real reason, which would be disagreeable and painful, but a reason that is plausible and much more satisfying to one's self-esteem. "I did not apply for a commission in the Medical Corps during the war because I could not be spared from my own community." A true reason in many cases; a rationalization in others. Not meeting the situation does not resolve the mental conflict involved in the situation and this lives to assert itself in many undesirable ways.

There is probably no snare of greater importance to the student than that involved in the development of a feeling of inferiority, for the injuries received here will likely remain with him for the rest of his life. The sources of this feeling are many and cannot be entered into here, but in any adolescent group the infected can be found. There are many types, but probably two of the most common may be discussed. The one is quite obvious, the other more deceptive. The one shows quite clearly by his demeanor that for some reason, quite likely a false one, he has found himself inferior and is accepting his lot. To the puzzlement of his associates, he may occasionally burst out in a show of strength, usually at an inopportune time and over unimportant matters, but this only leaves him more defeated and humiliated. Or he may find relief in coming to consider himself "different," of a finer and more sensitive quality than his fellows, to make capital out of idiosyncrasies, to sentimentalize, to invite moods, and to believe eventually that he is not made of rough world stuff, but that he is essentially spiritual and poetical.

Quite in contrast is his fellow student who, in his adolescent judgment, thinks he, too, has seen a specter of inferiority, but who buckles on a thick armor of bravado and defends himself by attacking. The idea that he may be inferior is intolerable, and he endeavors to prove to himself that he is not by developing an enormous self-conceit and by attempting to bowl over opposition. He may not be an unattractive youth and is likely to "get by" for a time, but his device is a boomerang.

Equally confusing to the individual and probably even more important in its complicated social effects is the process students find of transferring emotions. Something must be done with a strong emotion. It will not evaporate. It may be partially satisfied by rationalizing a cause for it, or one may rid one's self of it by assigning it to elements in the environment. Borne down by a sense of failure and inadequacy, self-respect may be maintained by finding the cause not within one's self, but in the unfairness and the unjustness and the misunderstanding of others. They and not we are to blame; self-respect is in part maintained, but at the cost of a habit that is insidious and capable of much elaboration and development. Emotions may be transferred bodily, so that what is in reality a dissatisfaction and disgust with one's self becomes an intense dislike and antagonism towards another individual against whom we have no cause for complaint, except—and this we may realize but vaguely—that he somehow keeps us aware of the deficiencies and inadequacies we are trying to ignore.

These and similar reactions, simple and harmless as they may seem, lead, as those who have cultivated them move in life to more critical and complicated relationships, to many perplexing personal and social difficulties.

During the social confusion of the last few years, there have been those who have been puzzled or alarmed or angered by the apparent radical tendencies of college groups. On the whole these "radicals" have been among the more intellectual of the students, in spite of the fact that some have found reason to question their intellectual capacity and others have considered them "cracked" or not just right in the head. Few, I think, except in psychiatric circles, have considered them university casualties and yet, clearly, that is what many of them are. The intellectual ability of many cannot be questioned, whether we approve of their views or whether we do not, but the mental integrity of others is quite open to question. Two men may hold identically the same opinion on any given subject and one may be mentally sound and the other mentally sick. The sanity or lack of it is not to be determined by the opinion, but by the source of the opinion. Very many of these young radicals—and just as truly very many of their most zealous opponents, both old and young—are of, or derived from, the group of students we have been discussing—students whose intellects and whose physical condition have been carefully attended to, but whose emotional lives and habits have been permitted to take their own course. Finding no other suitable outlet, emotional energies generated at sources quite apart from and bearing but slight if any relationship to the situation at hand (usually quite ascertainable sources) have flown into these social situations. At first the student may be quite surprised at the intensity of his reaction to a situation about which he thought he had some doubt. He is somewhat taken aback by the strength and sharpness of his ability to "hate" and to "admire," in spite of a faint intellectual questioning. But whatever of intellectual doubt there may have been in the beginning is soon swallowed up in the intensity of his emotions and his (emotional) personal reaction to a situation is taken as a personal understanding (intellectual) of the situation. In such a position he is impregnable, for direct assault is not possible. We blame him for the harm he may do. In time of war we throw him into prison and in time of peace we hurl epithets; if we have any feeling of responsibility for him, it is probably no more than a weakly eugenical one of blaming ourselves for ever having permitted him to be born.

In no case is the process quite as simple as I have described it. These few types of reactions that I have discussed do not occur singly, but in various combinations one with the other and with many deeper-lying and more complicated reactions that I have not discussed, until the result becomes the seemingly inexplicable thing we know as temperament or personality or idiosyncrasy or queerness or disease, depending upon the qualitative or quantitative variant of its elements, but, in any case, all off the same piece of cloth. Thus the fount from which pours our emotional life may be poisoned at its source. Our personalities cannot endure naked before the forces that assail them any more than can our bodies. Protection of some kind becomes necessary, but in building our protection we build clumsily, for we burden ourselves by seeking to protect ourselves, not alone from the forces, but from the fears that for us still reside in the forces. In the physical field knowledge has made us more skillful. We erect roofs over our heads to protect ourselves from the elements; but we are helped by knowing that those roofs are to protect us from the rain, the wind, and the cold, and not handicapped by believing we must build against demons and angry gods that reside in these elements.

In spite of increased skill in training intellects and in spite of increased facilities for the protection of the physical health of students—and more power to both of them—the goal, if that goal be the increase of human happiness and efficiency, will not be reached by these alone, for neither happiness nor efficiency is fundamentally dependent upon them. Emotions as well as intellect and mental health as well as physical health must be made a part of the program. In thus widening our program we will have immediately in mind:

1. The conservation of the student body; that intellectually capable students may not be forced unnecessarily to withdraw, but may be retained.
2. The forestalling of failure in the form of nervous and mental diseases, immediate or remote.
3. The minimizing of partial failure in later mediocrity, inadequacy, inefficiency, and unhappiness.
4. The making possible of a larger individual usefulness by giving to each a fuller use of the intellectual capacity he possesses, through widening the sphere of conscious control and thereby widening the sphere of social control.

EXPERIMENT TO DETERMINE THE POSSIBILITIES OF SUBNORMAL GIRLS IN FACTORY WORK*

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THE unusual conditions of the past four years—the enlistment of large numbers of men in the army and the flocking of workers from the more stable industries to the ammunition factories—resulted in a shortage of labor so serious that industries were obliged to draw upon every possible source of supply, even including what had previously been considered "the human scrap heap." People who once would have received no consideration were now able to obtain employment and to command good wages for poor work. Soon it became apparent that many of these workers were subnormal, and as a result of this new element in labor, new difficulties arose. Industry was suddenly confronted with an abnormal situation, which it was wholly unprepared to meet.

One of our largest rubber companies, being confronted with this problem, set about finding a solution. This company owned a number of factories in the Eastern part of the country. In common with other industries, they were forced to employ a low grade of labor, and they realized, as most industries did not, that this included many subnormals and that many of their labor troubles were due to this fact. They were far-sighted enough to see that it would be advisable to study this new type of labor and determine just what were its possibilities. There was every indication that in the future subnormals might have a permanent place in industry, since subdivision of labor had replaced the skilled workman, able to perform an intricate piece of work, with many workers, each performing one simple task and knowing little or nothing of its relation to the product as a whole.

The rubber industry is far less advanced in this respect than almost any other; in fact, it is the only large industry that still remains a handicraft. Only recently has subdivision of labor been attempted and it is still in its infancy; in many instances a rubber is still made by a single maker from start to finish, without the aid of machinery. For this reason, more jobs suited to subnormals could have been found in almost any other industry. Yet even here the breaking-down process had begun, and there was already an increase in monotonous jobs, requiring less skill and less mentality. It was thought that if the less intelligent workers could be placed on these unskilled jobs, leaving the more difficult jobs for the higher type of workers, it might help solve some industrial problems. It would serve as a means of promotion for the higher-grade workers, while those with less intelligence would be satisfied with monotonous, unskilled jobs. This might decrease labor turnover and be of benefit to all the workers.

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* This experiment was conducted with the advice of Dr. Arnold L. Gesell, Professor of Child Hygiene, Yale University.

It was evident, however, that subnormals must be handled by different methods from those employed with higher types of workers. They were often misfits; they did not get on well with other workers and they were difficult to manage. Also, it was apparent in many cases that they were not suited to their jobs. To determine what types of job were within their capacity and to bring out points of management that would help the industry to deal more efficiently with them, it was decided to undertake a piece of research work with them, to be conducted as far as possible on a strictly scientific basis. A person experienced in working with subnormals was found to conduct the experiment. Professor Arnold Gesell of Yale gave the new venture the benefit of his advice. It was, of course, necessary to have controlled conditions. Subnormals could not be studied to advantage in the factory. In order to obtain results of any real value, it was planned to study a small group in a separate workroom, which was to be considered as a laboratory. Data as complete as possible were to be collected upon all phases of the problem, psychological, social, and economic. Such an experiment had never been conducted before, and offered interesting possibilities.[1]

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[1] Although an experiment like ours had never been tried before, yet there has been some work with subnormals along industrial lines. See *Colony and Extra-institutional Care for the Feebleminded,* by Charles Bernstein. MENTAL HYGIENE, Vol. IV, pp. 1-28, January, 1920.

The work was carried on from March 29 to December 1, 1920, when it was temporarily discontinued because of business depression. Even in this short time results were obtained that are of value to the industry and that will, we believe, be of interest to many people outside. Although we have naturally emphasized the economic aspect, we have also been deeply interested in the psychological and social sides of the question. While results of this nature are less tangible, they are perhaps of even greater significance.

Since most rubber footwear is made by girls and women, it was decided to conduct the experiment with subnormal girls. The first step, naturally, was to secure a suitable group of girls with which to work. It was considered advisable not to transfer from the factory workers who were known to be subnormal—as this might arouse prejudice, and our success depended in part upon the goodwill and coöperation of the factory—but to obtain candidates from outside sources, with the help of the various organizations in the city.

Here we encountered our first difficulty. The state labor law requires that in order to obtain a working certificate at the age of fourteen, a child must pass an examination. Most subnormals cannot pass this examination and therefore cannot be employed in industry until they are sixteen. A clause in the law provides that girls may do housework at home. We found that because of the general labor shortage, subnormal girls of sixteen had no difficulty in finding employment. In one part of the city, they were working in a corset factory, where there are many simple jobs, such as putting in eyelets, lacings, etc. They were also employed in various other factories throughout the city. Figures, so far as obtained, showed that their wages ranged from $10.50 to $23.00. In one case a subnormal girl worked in a wire factory during the summer for $15.00 a week. As she was unable to pass the examination for a working certificate, she went back to school to a teacher earning $12.50. We investigated the case of a shoemaker in our own factory, known to be subnormal. She had the reputation of being a very poor worker, but her earnings were from $20.00 to $23.00 a week. We were told that she would not be tolerated under normal conditions, but since labor was scarce, they had to put up with her.

We had expected to find candidates in the special classes of the public schools, but here again we found difficulty. These classes are largely filled with boys; there are comparatively few girls, and what few there are drop out at fourteen, under the clause of the law that permits them to do housework. As there is no follow-up work, they are lost sight of so far as the school is concerned.

The result of this situation was that the only candidates available for the experiment were those who could not obtain employment, who had tried other industries and failed, or whose personality was such that they could not adjust themselves to normal conditions.

It was finally decided to begin the experiment with such candidates as we could obtain, with the hope that the work would gradually enlarge as it became better known. The class was opened March 29, 1920, with three members of a low-grade type—from six to eight mentally—who could not possibly obtain work elsewhere. It was five weeks before we were able to increase this number. Since, by the end of June, there were only seven members, it was decided to fill up the class during the summer with girls between the ages of fourteen and sixteen from the special classes in the public schools. During July and August, therefore, there was a membership of fourteen. This required a larger room and an assistant. In September the minors had to be dismissed, leaving only six members in the class, but during the month of November, the effects of the labor depression were beginning to be felt and there was a decided increase in candidates, which enabled us to choose those best suited to our purpose and weed out the less desirable members. By this time, too, our work had become established in the community. The various social organizations had had an opportunity to watch its results through individual cases in which they were interested. Incidentally, they have all expressed their belief in the value of the work from a social point of view and their regret that it must be given up, even temporarily.

When the class closed, on December 1, there was a membership of twelve and a waiting list. Twelve was as large a number as could be accommodated at that time. Moreover, the best results, from an experimental point of view, cannot be obtained from a larger number without increased supervision.

Altogether twenty-three girls have been enrolled in the special class. Because of our difficulty in obtaining candidates, almost every one who was recommended was taken on trial until the last month. A complete case history was made of each girl, including her family background and environment, physical record, and personality. This was supplemented with a work record and a full history of the case as observed in the special class. Every girl was given the Stanford Revision Tests, and also tests with concrete material, supplemented by other tests in visual and auditory memory and motor control.

The individual differences between subnormals are even greater than among normal workers. Each one must be handled as an individual problem. We have had, however, two general types. The first is the imbecile group, from five to seven mentally. These girls could not obtain work under ordinary conditions, but succeeded fairly well in the special class. They were able to perform simple, monotonous jobs, which required almost no skill or mentality. In work of this kind they were able to earn from $8.00 to $10.00 a week at factory piece rates. Since they are generally of the dull, inactive type, they are very little trouble if placed where they are not annoyed by other workers. For this reason, and because the work they do is of the simplest nature, they require little or no supervision when once trained, and become contented, faithful workers. Another, and by no means minor, consideration is the fact that they are thus made self-supporting. Otherwise they must inevitably be a burden on the community.

The more important group is the moron, from eight to eleven mentally. These are girls with limited intelligence, but capable of developing in industrial work that requires only a moderate degree of skill and mentality. They usually do not acquire great speed, in most cases about two-thirds of the standard daily production. Occasionally, however, one of them makes a greater effort, or shows more manual ability, and develops into an excellent worker, a distinct asset to the industry.

An example of this type is Carmella D———, sixteen years old, nine years, eight months mentally. She is the oldest of fourteen children, nine of whom are living, and all of whom are said to be of the moron type. She had tried doing housework, but was discharged for mistaking the dish towel for a handkerchief. The Visiting Nurses' Association recommended her for the special class. They were anxious that she should be employed, as she was going with undesirable companions. From May to September she showed no special ability. Her production was low and her work sometimes poor, but she was always faithful and appeared to enjoy her work. In September, when one of the girls was discharged, Carmella was much impressed. She suddenly realized that there was a possibility of losing her job. Under this stimulus, she began to work as she had never worked before. By this time she had had sufficient training, and the result was most surprising. In a short time she was earning $17.00 to $18.00 a week on joining linings. After about three weeks, she was obliged to change work, and other conditions were unfavorable, so that she fell back noticeably. Later, when given another steady job, she earned $14.00 to $16.00. When the class closed, she was transferred to the factory.

It is chiefly from this moron group that the special class should be built. On the whole, they are the most troublesome type. They need constant supervision, both in their work and in their conduct. A "big stick" is often necessary. They are undoubtedly a menace to the community, but our experience has shown that the best thing that can be done for them is to give them occupation under the right kind of conditions.

When the class was organized, it was suggested that it might be a means of experimenting with various types of handicapped workers. This suggestion has been carried out. We have had two deaf girls, one blind girl, and one psychopathic case. The results obtained were sufficiently good to justify a continuation of the experiment with workers handicapped in these ways. The two deaf girls developed into excellent workers; one of them has been transferred to the factory and the other has been, through our influence, placed in a school for the deaf. We had had the blind girl only four weeks when the class closed and do not feel that this was long enough to prove very much, but we had found that she was able to do satisfactory work at the job of piping linings, which is largely a matter of feeling. The psychopathic case —a woman of twenty-two with a mentality of eleven, who had frequent seizures of an epileptic nature—showed marked improvement in health and self-control during her first two weeks with us. Then serious family trouble developed which offset the good effects of her work, and she was finally committed to a hospital as insane. We do not consider this case a complete failure, however, in view of the improvement during the first two weeks. Had home conditions been more favorable, we could probably have accomplished much with her.

The selection of work suitable for such a group as ours was, of course, important. The more a job can be subdivided and the more it can be handled by bulk, the better it will be suited to subnormal labor. Jobs that require more than a limited degree of mentality and skill are beyond the capacity of the subnormal. This limit varies, however, with each individual.

The imbecile group could do nothing more difficult than picking the paper from certain parts of the rubber shoe and laying the pieces neatly in rows of twenty-four. As some of the girls were unable to count correctly, they were taught to make rows of six and put four sixes together. As soon as more accurate counting was required, they were a failure. There is a large amount of this picking to be done, however, and they can be made very useful at it.

The moron group could go much farther, but still had their limitations. They worked on what is known as "fitting up jobs." This work consists in preparing the various parts of the rubbers before they are sent to the makers' tables. They were able to do any of these jobs, with the exception of laying and cementing linings, which require too high a degree of skill and too high a standard of workmanship. They can be trained to take pains up to a certain point, but beyond that point they cannot go. They cannot handle a job that has many parts to keep track of or too many steps to be learned.

The amount of individual production varied considerably. The girls were easily influenced by conditions both outside and in the workroom. In order to obtain the best results from the experiment, we tried to have the physical conditions ideal, so far as possible. We paid special attention to lighting, adjustment of seats, etc. We have also been able to note the effects of unfavorable physical conditions. For example, during the fall, when the room was not heated, production fell off noticeably on chilly days. Each readjustment to a new job or to changed conditions meant a temporary decrease in production. The girls did much better if given one job at which they could work steadily day after day. Monotonous jobs, therefore, are particularly suited to them. They have one advantage over average workers in that the cleanliness or dirtiness of the job is a matter of indifference to them. In setting factory rates for cementing jobs, compensation has to be made for the dirtiness of the work, but this is not necessary with subnormals.

For the first three months we paid a flat rate of $10.00, or about 87 per cent of the factory rate for new employees. But the first members of the class belonged to the imbecile group and were not capable of earning this amount. Moreover, while they were on a flat rate, they were not putting forth their best efforts. Therefore, in July we introduced a sliding scale. The minimum wage was reduced to $8.00, and the amount of production required for this rate was reduced 14 per cent, making it easy for them to exceed the minimum. For the $9.00 rate, the standard was reduced 8 per cent. For the $10.00 rate and above, regular factory piece rates were paid. This served to stimulate production and to reduce the expense of the class. New girls were paid $10.00 for three weeks.

After November 1, 1920, it was decided to pay altogether by piece rate. By this time, the girls who had been in the class had had the benefit of training and practice, and the new workers were of a little higher type. Except for three poor workers, who were dismissed, even the lowest grade members of the class were able to earn $8.00 or more by actual piece rates.

We had begun an investigation of class wages that promised to have a very practical value. Factory piece rates are based on time studies and upon a class wage, which is usually determined by the foreman's opinion of how much a person on that job should earn. The actual requirements of jobs seem to receive little consideration. We found that the rates were very uneven. Therefore, it was decided to make a special study of this question since we had a specialized group under controlled conditions, which gave us an opportunity to try out different jobs and demonstrate results to a degree not possible in the regular factory. Some data had been accumulated when the class closed, but the investigation was far from complete. It may result in a reclassification of jobs according to the mentality and skill required. Jobs below a certain standard could then be given a lower class wage and left to the workers of a lower type. If such a scheme could be worked out satisfactorily, it would be of value both to the workers and to the factory.

The objectionable characteristics of subnormals are sufficiently obvious, and need no comment. Our experiment showed, however, that they have certain desirable qualities, not often appreciated, but well worth considering. They are very reliable. If given sufficient training in some simple task, they can be depended upon to perform that task indefinitely. In a recent number of *The Atlantic Monthly,* there appeared an article by Carleton H. Parker in which he describes a scene in the Chicago stockyards: "We stood with the superintendent in a room of the canning department. Down both sides of a long table stood twenty immigrant women, most of them visibly middle-aged and mothers. 'Look at that Slovak woman,' said the superintendent. She stood bending slightly forward, her dull eyes staring straight down, her elbow jerking back and forth, her hands jumping in nervous haste to keep up with the gang. These hands made one simple, precise motion each second, thirty-six hundred an hour, and all exactly the same. 'She is one of the best workers we have,' the superintendent was saying. We moved closer, and glanced at her face. Then we saw a strange contrast. The hands were swift, precise, intelligent. The face was stolid, vague, vacant. 'It took a long time to pound the idea into her head,' the superintendent continued, 'but when this grade of woman once absorbs an idea, she holds it. She is too stupid to vary. She seems to have no other thought to distract her. She is as sure as a machine. For much of our work, this woman is the kind we want. Her mind is all on the table.' "

This is an excellent picture of a certain type of subnormal. As this superintendent said, "it takes a long time to pound the idea into their heads," but for certain lines of industry it is worth while. Because of their lack of mentality, they are perfectly satisfied with a simple, monotonous job, and therefore much more apt to remain permanently than workers with more active minds. They realize vaguely that they do not fit in ordinary positions. When placed under some one who understands them, and who gives them the extra attention and encouragement that they need, their personal loyalty is very great. Under the right conditions, subnormals will become the most reliable of workers, sticking to their jobs indefinitely, with not a thought of change.

These facts are significant in the light of turnover and absenteeism, two items that loom large in all industrial cost accounting. Undoubtedly the instability of a large per cent of the workers does much to increase the cost of production in all lines of manufacture. It is, therefore, interesting to compare the record of subnormals in this respect with that of the average worker.

The special-class turnover cannot be fairly estimated in figures because we have not exercised the same selection in our group as in the employment office. We have been obliged to handle the down-and-outs. They come to us only because they have little chance of success elsewhere. Many of them are taken only on trial. Therefore, it is to be expected that we have had some turnover that could have been avoided by other methods.

TURNOVER OF SPECIAL CLASS

Admitted to Special Class

Very low grade or failures elsewhere	8
Physically handicapped (blindness, deafness, etc.)	3
Might have been hired elsewhere	3
Under age—hired for summer	7
Taken for observation:	
Psychopathic case	1
Civic protective case	1
Total	23

Left Special Class

Under age—hired for summer	7
Voluntarily	2
Committed to institutions	1
Physical condition	1
Sent to school for deaf	1
Discharged:	
Insubordination	1
Poor work	3
Total	16

Returned to Special Class Later

Reached age of sixteen	1
Passed examination for working certificate on third trial	2
Unsuccessful elsewhere	2
Total	5

As is indicated in this table, the majority of those enrolled had been discharged from other places or were unable to secure employment, even when there was the greatest demand for labor. Of the girls employed for the summer, another became sixteen in December and would have returned had the class continued. The other three begged to remain, but could not be permitted to do so under the present law. They are staying at home until such time as they may be allowed to return. Only two left of their own accord, and both returned after trying other work. Every one who has left or been discharged has expressed a desire to return.

The absenteeism in the special class was astonishingly small. For a period of eight months it was only .36 of 1 per cent. The factory in which the experiment was conducted averages about 5 per cent. This again illustrates the faithfulness and reliability of subnormal workers.

We were much pleased with the way in which the experiment was received by the factory employees. From the first, their attitude was one of friendly interest, which increased as time went on. From every department we received the heartiest coöperation. The forewomen, and also the workers, were put to a good deal of inconveniece at times, but they were always most considerate. They often expressed the feeling that they were glad to see these people have a chance.

At first it was thought inadvisable to take workers from the factory, but later a number of girls were transferred and there was no difficulty. It is now understood that when a new worker fails to make good, she is to be tried in the special class before being dismissed.

One of the most gratifying results has been the happy, contented spirit of all the girls, and their loyalty to the class. It provided what they most needed—occupation suited to their capacity, direction, supervision, and companionship. Some of these girls had been giving much trouble outside. When provided with suitable employment, they no longer found time to get into mischief. This improvement in the individual girls has frequently been commented on by nurses, social workers, and other people who are interested in them. It has done more than anything else to convince the public of the value of the experiment, and has been a distinct service to the community, but one that cannot be measured in dollars and cents.

Even the dullest girls waked up and accomplished more than any one had expected of them. Pamela T————, for example, is a girl who came to work for the summer. Her chronological age was fifteen years and nine months, her mental age, six years. She is noticeably subnormal in appearance. Her face is expressionless, and she carries herself badly. She has a serious eye trouble which cannot be helped by glasses. Her disposition is sullen and excitable. She is very sensitive and appears to be most unhappy, probably because she has had a very hard life. According to the school report, she has "no power of concentration, very little ability, and requires much coaxing." Altogether, she appeared to be as hopeless a case as had come to the class. When she began picking heel lifts, she laid them very badly, but improved in the course of a week. To our surprise, she turned out to be a very good worker on the simple jobs. The heel lifts could not have been done better, and she gradually increased in speed. By the end of the summer, she was averaging about $9.00 a week. She was also able to do other picking jobs requiring a little more skill. She could probably have been trained to do some of the other simple jobs. She had to be dismissed at the end of the summer, but in November she became sixteen. She then secured a permanent working certificate, and was in the class about a week before it closed. The work that she can do is necessary and must be done by some one. She is just the type to do it. Whatever she does is well done. After her training in this class, she could be transferred to the factory and would probably make good, if not annoyed by other workers.

Only two of the girls were failures. They were lazy and indifferent workers, showing little possibility of development, and were a hindrance to the others. After a reasonable trial they were discharged, with good results to the rest of the class.

It is unfortunate that the work had to be given up when it was but just organized. We hope, however, to start again as soon as the business situation changes. There are interesting and untried possibilities in work with subnormal boys. In interviewing the social agencies, we were told that they could recommend plenty of boys, and that they needed supervised employment even more than did the girls. But it was, of course, inadvisable to have a mixed class, and in the rubber industry there are fewer jobs suitable for boys, and they are jobs that cannot be separated, but must be carried on in the regular factory. Therefore, we have as yet done nothing along this line.

Some points with regard to the management of subnormals that were brought out in our special class may be of use in other lines of industry and serve to decrease the dissatisfaction of the workers as a whole, since subnormals, if improperly managed, are a constant source of friction.

Whenever possible, the training of subnormals should be carried on away from other workers. Supervision and discipline, which are the chief problems of the special class, are made much easier in a separate workroom. Then, too, it is inevitable that workers of this type will be made fun of and annoyed in various ways, if allowed to mingle with other employees. This is bad both for them and for the factory. This difficulty is almost completely avoided by a separate location.

It goes without saying that subnormal workers require a longer period of training and much more patience in teaching. They are apt to be careless in their work, and a good deal of effort is necessary to establish correct habits with each new job. They get into all sorts of difficulties that a normal worker would avoid. They are not capable of planning their work or of keeping track of it until after long training. In fact, some of them never reach that stage. But in most cases, if given the right kind of job and proper training, they gradually acquire correct habits of work and develop into very good workers. Left to themselves they inevitably fail. We have had a number of girls who had been shifting jobs constantly, but who remained in the special class as long as it continued.

The supervisor should be a person of infinite patience and tact. He should understand the limitations of the type with which he is dealing and not expect results beyond their capacity or lose his temper with them. In most cases when they offend, it is quite unintentionally, and often because the director himself has failed in his method of management. One principle that should always be borne in mind is that subnormals should not be constantly made aware of their lack of mentality. Such words as "stupid," "fool," etc., should never be used under any circumstances. Most of them have heard these terms all their lives. If one wishes to draw out what little ability they possess, one must never make them feel that they are different or less capable than other workers.

In order to achieve the best results, it is necessary to make use of every possible incentive. Each case must be dealt with individually. Some workers need to be treated with severity, in order to bring out their best efforts, but with the majority, frequent praise and encouragement are far more effective. For this reason the supervisor should go out of his way to give encouragement. When work must be criticized, the worker should not be made to feel that it is altogether wrong. Something good about it can usually be found—"You have done this part well, but——" Most of these people have been found fault with constantly and are easily discouraged. It is poor psychology to discourage them any further. So long as they do the best they can, as they do in most cases, they deserve a certain amount of credit.

Rivalry with other workers of the same type is often useful.

They are also interested in simple charts or other devices which show their progress. The method of arranging their work is worth considering. Production figures, or even wage figures, mean little to them, but a pile of work upon their table is real and concrete. It is a good plan to determine about what they should do and place the whole pile of work before them, saying that it must be done by the end of the day or perhaps by the end of the morning. They will then work industriously to finish the pile. They like to finish something, and are quite as well satisfied with a small pile as with a large one. The amount can gradually be increased. The special class demonstrated that subnormals differ from normal workers in that pecuniary reward is not a sufficient incentive for them. The pay envelope, generally speaking, does not mean as much to them as it does to other workers. This is probably because they do not assume the responsibility of their own support. They are pleased with more money, but not disturbed if they receive less.

The example of one of their own number has great influence. If by any means one member of the class can be made to increase her production, the others are immediately interested and an improvement in the whole class will result. Unfortunately the reverse is also true.

Since subnormals lack responsibility and are easily influenced, strict discipline is more necessary with them than with other workers. It is also necessary to have some one constantly in the room. There are always one or two workers who are inclined to make trouble. The best way to avoid difficulty is not to allow any opportunity for it to arise. Whenever any occasion for discipline arises, the method of dealing with it should be prompt and effective. Since one cannot appeal to reason, with these workers, to any great extent, the less said, in the way of discipline, the better.

Fear of losing their job is perhaps the most important stimulus that can be brought to bear upon them. They all like their work, and dread the thought of leaving. Dismissal, of course, is to be avoided if possible, and never resorted to without adequate reason. When it becomes necessary, however, it should be done in a manner which will make it effective. One of the most significant results of our experiment was the psychological effect of the discharge of one of the girls. This girl refused to obey the assistant, was impudent, etc. Her prompt dismissal was felt to be just by all the other workers. Had any less drastic measure been used, the effect would have been undesirable. The result was an astonishing increase in production. The two best workers gained nearly 100 per cent, and the lower grade workers 30 per cent. This increase was sustained for about three weeks and then fell off somewhat, because the work had to be changed and other conditions were unfavorable. Later, when favorable conditions were restored, almost the same standard of production was reached.

This raises the question as to whether production is not closely allied with discipline. In the special class we have demonstrated that there is a very close connection. We know that subnormals are employed in many industries, particularly in those requiring less skilled labor. It is quite possible that if stricter discipline were enforced, and some of the special class methods introduced, production might be generally increased. The special class has shown that with workers of this type the enforcement of discipline does not lead to discontent. On the contrary, they are more contented. A wholesome respect for authority is always desirable, and if they are made to feel this, it will not be necessary to keep discipline constantly in the foreground.

Our experiment has shown that improvement of state legislation in regard to subnormals is urgently needed. A few states already have excellent laws, but the majority are far behind the times. We have already spoken of the labor law of the state in which this experiment was conducted, which requires an examination in fractions for all children under sixteen before the granting of a working certificate. This or any other legislation that tends to raise the school requirements for normal children is highly desirable. The result is, however, that the bright child, who would benefit by remaining in school, can easily pass the examination and go to work. The subnormal, on the other hand, by the age of fourteen has reached the limit of his mental capacity and gained all that the school has to offer him. If he remains in school, he is simply a burden or a nuisance. Frequently, however, he drifts out. The girls usually remain at home, under the clause in the law that permits them to do housework. Very often they spend much time on the streets and are a constant source of trouble. It would undoubtedly be much better for them to be suitably employed. Under present conditions, these two impressionable years are often worse than lost.

The effect of the present law may be illustrated by the case of Angelina D———. She is a very attractive girl, with no suggestion of the subnormal in appearance, although she is a little less than eight years mentally. She is very polite in her manner, and very likeable. For this reason, with her immoral tendencies, she is the most dangerous type of subnormal girl.

The special-class teacher, the Visiting Nurses, and social workers all urged us to employ this girl, because she was staying out at night and causing trouble. They felt that suitable employment was what she most needed. Her school age was given as fifteen, but we found that this was incorrect. Her real age was thirteen years and eleven months. This meant that we could not employ her, even in vacation, until she had passed her fourteenth birthday, on August sixteenth. In the meantime, it was said that she was behaving badly. One night she climbed out of the window and ran away. The method of treatment employed by the family was continual beating. Her mother pulled her hair and hit her across the face. Her brother beat her almost to insensibility every night. Naturally this did no good.

On August sixteenth, she arrived bright and early and remained at work until school opened. During the two weeks she was with us she worked well and was absolutely no trouble. We also received excellent accounts of her from home. Apparently she had turned over a new leaf. She stayed at home nights and was no longer a source of worry to the family. Her parents were delighted and could not say enough in praise of the class. They begged us to keep her, but the law would not permit us to do so. Much as we regretted it, she had to be dismissed.

She went back to school, with the hope of learning fractions, so that she might obtain a working certificate. We soon heard that she was becoming troublesome again. In November came the news that she was married to a man of twenty-eight. At first she appeared with jewelry and new clothes, but her husband had no work, and these were soon pawned. She has since hardly had enough to eat and is very unhappy. The moral of this tale appears to be that in order to go to work one must pass an examination in fractions, but that one need not know anything at all to be married.

This girl is but one of many who are in need of occupation. There is an even larger number of boys in the same situation. Nothing could be worse for them than to remain idle. The indirect effect upon the community is far more serious than is generally realized. Some states have a clause in the law by which subnormals may be permitted to secure a working certificate without passing an examination. Such a certificate is not granted except upon the signature of the school supervisor or other competent authority. In some states a psychological examination is first given; in others, a "vocational probation" is granted through the court. It is necessary to safeguard such a provision very closely or it will be misused. On the other hand, it is a grave injustice not to make some provision for children of this type. The present tendency is to raise the working age from sixteen to eighteen, in order to give children more education. Unless some special legislation is introduced, this will make the situation still more difficult for subnormals.

We have often wished that there might be closer coöperation between the schools and the industries. We would have been glad to make our experiment a vocational continuation class for the special class of the public schools, but under existing circumstances this could not be brought about. It is an object worth working for, however. It is to be hoped that the time will come when education and industry will work more closely together, along many lines, to their mutual benefit.

Dr. Pearce Bailey[1] describes a moron as "one capable of earning a living under favorable circumstances, but incapable of competing on equal terms with his normal fellows." He goes on to say, "It is now generally known that the effectiveness of a mental defective depends less, within certain limits, upon the grade of mental defect than upon the habits of *doing* that he has acquired. An individual with a mental age of eight years who has definitely acquired habits of industry, obedience, and regularity is a far more useful member of society than a high-grade moron who has never acquired such habits. It is the quality of training that has been given, rather than the intellectual level, that concerns the employer of this variety of labor, whether such employer be a recruiting officer or some other."

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[1] See *Mental Deficiency; Its Frequency and Characteristics in the United States as Determined by the Examination of Recruits,* by Pearce Bailey. MENTAL HYGIENE, Vol. IV, pp. 564-596, July, 1920.

Training is, indeed, the key to the situation. A large proportion of border-line cases will never be cared for in institutions. Their training should begin in the special classes of the public schools. From there the natural step should be directly into some form of occupation, under the guidance of the after-care worker. Agriculture, domestic service, and simple routine factory work are the types of occupation best suited to them. Industrial work, without training or supervision, will not produce satisfactory results. If the industry is unwilling to assume the expense of training such a group of workers, it would be well worth while for the state to pay the salary of a director, as is often done in Americanization classes, leaving the industry to provide the work and the overhead.

There is no more practical or less expensive method of providing for the large numbers of defectives who must remain in the community. We know that they are incapable of assuming responsibility. They are children who will never grow up. The majority of them are not vicious. They are potential criminals only because they are easily influenced and the victims of environment. The responsibility is ours. We must not allow them to drift into idleness and crime. By providing proper supervision and occupation, we may be able to render them self-supporting, useful members of the community. Therefore we offer such incomplete data as we have collected, with the hope that industrial classes such as we have described, but more completely and efficiently developed, may have a place in the constructive program of the future.

VOCATIONAL PROBATION FOR SUBNORMAL YOUTH

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NOT many years ago institutional segregation was regarded as *the* solution for the problem of feeblemindedness. In discussions of the subject it was gratuitously assumed that a feebleminded person is one who really ought to be in an institution. We are gradually coming to a more reasonable and a more humane point of view. The excessive expense of wholesale segregation has had a deterrent effect; so has the potential economic value of the high-grade defective. The instinctive affection of the brothers, sisters, and parents of the feebleminded has also resisted undue institutional segregation.

Accumulating evidence that the moron, and even the high-grade imbecile, do not completely fail in ordinary life under favorable conditions has suggested the possibility of creating these conditions outside of institutions. The notable work of Dr. Charles Bernstein in providing extra-institutional supervision for feebleminded young men and women on parole has taken the subject out of the field of mere speculation. The concrete and positive results of the experiment in which Miss E. B. Bigelow definitely determined the possibilities of a group of subnormal girls in factory work have added a new and very significant piece of evidence in favor of non-institutional community control of certain mental defectives.

The writer has been able to follow from its inception the details of this interesting experiment described in the foregoing article by Miss Bigelow.[1] The unique significance of the enterprise, from a sociological standpoint, was that it dealt with a group of subnormal girls who never had been committed to an institution and who were not even on a parole basis. For the most part these girls had but recently been in public school. Miss Bigelow came to the problem with five years of experience in special-class work in Boston, and she virtually adapted the methods and the principles of the special class to industrial conditions and demonstrated that subnormal youths can be given special training and productive employment in factory work. Just as the special class has proved that by a differential type of treatment it is possible to maintain defectives in a public school, so it is now clear that by a similar approach we can solve the problem of community control of wage-earning defectives.

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[1] See page 302 of this issue.

Industry can undoubtedly afford to make certain internal adjustments in behalf of subnormal employees. If these adjustments by industry and by individual employers are supplemented by voluntary and official coöperation on the part of family, community, and state, it will be possible to keep an increasing number of defective youths at home. It is not necessary to send such youths to an institution for training and then to parole them. Commitment to an institution can be replaced by a consistent policy of supervision—of constructive probation.

How can such a policy be developed? We must not place our reliance on altogether novel and purely clever devices, but build securely upon experience by extending the scope of established law and of existing agencies.

First of all we have the tradition and the law of compulsory education. By historical sanction and actual administrative relations, our elementary school system constitutes our largest public-welfare agency. The great majority of mentally subnormal youth are either attending elementary school or have recently done so. We may, if we choose, use the term elementary school system in its most liberal sense to include private as well as tax-supported schools in so far as the former come legally within the scope of such public supervision as relates to physical and mental health.

This situation has made possible the remarkable growth of the special-class movement, which is resulting in special provisions for all types of handicapped school children except those who are altogether uneducable or unmanageable. The impetus behind the movement will extend equivalent special provisions to exceptional school children in rural and village communities. No one has ventured to advocate systematic exclusion of defectives from our public schools. Such a policy would lead nowhere, and is really in conflict with the spirit of the common schools.

Out of the principle of compulsory education has grown a vast body of law and administration relating to school attendance, school registers, medical inspection, vocational training and guidance, child labor, and certification of youthful candidates for employment.

Put in unqualified terms, the presumption in the typical American commonwealth is: (1) that every child has the right and the obligation to attend school, and (2) that the state shall determine whether he is ready for employment.

This fundamental relation of the state to children affects in a peculiar manner the subnormal pupil, who cannot profit by ordinary instruction and who cannot compete on equal terms with his fellows when he becomes of working age. This exceptional status of the subnormal creates an almost paradoxical situation. The school cannot exclude the moron on the one hand, and it cannot graduate him on the other. The only solution is a modification of law and practice that will safeguard the subnormal when he leaves school.

An opportunity for formulating a workable, legal solution of the problem presented itself in the work of the Connecticut Commission on Child Welfare. This commission was appointed by the governor in June, 1919, and was instructed by law "to embody in its report a proposed code of laws which shall include a revision of the provisions of the general statutes relating to children, with such changes and additions as it may deem advisable." The state of Connecticut appropriated a liberal sum of over $22,000 for the expenses of the commission, who have just reported a Children's Code which gives special consideration to the problem of the subnormal.[1]

A supervisory state bureau of child welfare, a division of special education and standards as a department of the state board of education to guide and encourage provisions for all types of exceptional school children, and a state-wide system of juvenile courts with well-trained probation officers constitute the main administrative proposals. These agencies articulate and are designed to strengthen rather than to supplant existing agencies, to define and extend the responsibilities of local agencies, and to coöperate with them in making their present work more effective. It is unnecessary to summarize the details; we shall simply quote the provisions which bear on the subject in hand—namely, the community control and supervision of mentally defective youth:

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[1] See *Report of the Commission on Child Welfare to the Governor,* in two volumes, published by the state, Hartford, 1921. In Volume II, see report on *Handicapped Children in Court and School,* by Dr. Arnold Gesell, Chairman of Committee on Defectives.

> "Any agent of the Bureau of Child Welfare or any representative of a child-caring institution or agency licensed by the Bureau of Child Welfare, or any reputable citizen may petition the judge of the Children's Court to establish supervision over or to commit to an institution any defective child or defective young person legally resident in the district of said court, who, in the uncorrupt judgment of the petitioner, is in need of protection and care for his own and for the public welfare. The petition shall set forth the facts necessary to bring such defective person within the purview of this act; whereupon the judge shall, after investigation, if he deems the petition sufficient, order a hearing in chambers on the case, giving due notice of such hearing to persons interested in the petition, if there be any."

This right of petition, carefully safeguarded by the law, leaves the initiation of procedure in behalf of the mental defective to either official or non-official persons and agencies. The implication is that mental deficiency is not to be concealed as a stigma, but treated with the same frank vigilance as disease or delinquency. The proposed juvenile court is regarded as a court of social adjustment, supervision, and active prevention with respect to child-welfare problems in general, and its jurisdiction is accordingly extended to mental defectives.

This is altogether logical, even if not usual. The juvenile court, like the public school, must adapt itself to the needs of all children who constitute potential social problems. Court and school alike are local institutions of and for the people; both are child-welfare agencies and it is their business wherever possible to reduce or to forestall the necessity of state institutional treatment.

The only way to meet this situation is to empower the juvenile court to establish a status of probation for all juveniles who need it, whether they be delinquent, potentially delinquent, or simply defective. In the case of the mentally defective, the probation should be put on a vocational basis and should represent an effort to keep the subnormal individual safely at some gainful employment in his own community, in lieu of commitment to an institution.

The application of this idea in the Children's Code of Connecticut is embodied in the following provisions relating to the *status of vocational probation:*

> "The judge of the juvenile court may, on the basis of evidence presented in accordance with provisions hereinafter specified, declare in behalf of any defective child or young person the status of vocational probation. This status shall not be declared when it is both expedient and desirable that the child or young person adjudged defective be committed to an institution. The court may, however, at its discretion, establish the status of vocational probation in lieu of commitment to an institution when the child or person in question belongs to one or more of the following classes and is legally resident in the district over which the court exercises jurisdiction:
>
> (a) Any child over 16 years of age or any young person who is adjudged to be defective, but who is physically able to undertake, under reasonable non-institutional supervision, some useful or gainful occupation in his home or within the corporate limits of the district of the court.
>
> (b) Any child over 16 years of age who has been declared dependent or neglected, but who, by reason of mental defect, needs special supervision if he is not committed to a public institution.
>
> (c) Any child who is over 14 years of age, who has been adjudged mentally defective, who on the testimony of a reputable physician is of sound and competent physique, and who on the petition of his parent or guardian and of the principal or superintendent of the school which he attends is recommended for part- or full-time employment at some useful occupation.
>
> "The petition shall be made on a form prescribed by the Division of Special Education and Standards of the State Board of Education and shall satisfy the judge that the child is actually defective and that his employment will be more favorable to his welfare than continuance in public or private school.
>
> "The court shall keep a register of children and young persons for whom the status of vocational probation has been established. Such child or young person shall be legally known as a vocational registrant or probationer. He shall be entitled to a certificate issued by the court which affirms this status, and describes the protection which the law aims to confer upon him.

> **"It shall be the duty of the probation officer attached to the court which has established the status of vocational probation to exercise a general supervision over each such vocational probationer in his district, to aid the probationer to secure suitable employment, to confer with his employer, his parents, or guardians to the end that said probationer shall not be committed to a state institution, but remain if possible with safety in his community. To this end the probation officer may confer with other public officials and representatives of local agencies, and he may delegate to such representatives powers of oversight and guidance.**
>
> **"He may also act as temporary conservator over the wages of said probationer on the order of the court. The probation officer shall report quarterly to the court on a form prescribed by the Bureau of Child Welfare concerning all such vocational probationers under his supervision, and whenever the report so justifies, the court may hold a hearing to determine whether the probation of said child or young person shall be continued or whether he shall be committed to an institution or to some other agency for custody or guardianship."**

This is the proposed law. We present it because it represents an effort to formulate a civic policy with reference to the most neglected phase in the care of the feebleminded. We realize that a law, even if adopted, bakes us no bread. A status of vocational probation for subnormal youth is not self-operative. It involves a system of safeguards; it assumes devoted probation officers, coöperative adjustments on the part of court and school officials, and a new understanding on the part of employers, foremen and forewomen and social workers; it may mean personal and environmental rearrangements within selected industries to meet the need of subnormal workers.

We appreciate that all of these requirements cannot be suddenly created even by an enlarged system of juvenile probation. We believe, however, that it is sound policy to unite the functions of moral and vocational probation and to coördinate them with the school system on the one hand and a juvenile court on the other. We cannot expect a probation officer to accomplish a superhuman amount of guardianship, but administratively his office may be used as the legal pivot for the organization of community supervision of manageable defectives and delinquents. Unquestionably the whole tendency of welfare work is now away from institutional segregation toward local community control.

OBSERVATIONS ON MALADJUSTED CHILDREN *

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IN tracing the development of medicine, one can see that those diseases which produced marked organic changes were the first to be intensively studied and understood. This was true in every field and has been well exemplified in that of psychiatry. Those mental diseases which showed structural changes, such as the psychoses due to syphilis, alcohol, and so forth, and those conditions in which actual structural defects can be demonstrated, such as the extreme degrees of feeblemindedness, were further studied, better understood, and therefore better treated. Compared to the functional neuroses, they are, after all, definite conditions. In recent years, however, such illnesses as apparently have no organic basis, but are the result of functional derangements, have begun to receive intensive investigation. The whole field of the ductless-gland disturbances, diseases of metabolism, such as diabetes, and especially the functional nervous diseases, such as the psychoneuroses, have been the conditions studied.

Naturally there was a shift in the attitude of approach and the method of inquiry. Organic medicine has long and hopelessly striven to fasten an organic basis on many diseases which are now thought to be the result of poor function rather than of changed structure. Instead of studying the disease by its end result in the changed structure of an organ after death, it became necessary to study the disease through its reflection in the behavior of the individual, or by means of its changed secretions or excretions.

If this were so, one would of necessity be forced to observe closely and patiently the complicated and often perverse function in order to discover its purpose, and then reëducate that function so that it could discharge its duty and satisfy the individual. This was especially true of those conditions which did not have a fatal termination, or where death came only after years of disease.

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* Report on Work of Children's Clinic, 1917-18, Department of Psychiatry, Cornell Medical School.

In psychiatry this trend in modern science brought into the center of attention all mental diseases in which at autopsy no brain changes could be demonstrated. Hypothetical intoxications, equally hypothetical constitutional diatheses, and bad heredity were discarded as causes for these diseases. The investigator, with open mind, viewed the suffering human being and asked himself: "Why does or must *this* human being use *this* particular mechanism in order to live? What forces, both in and outside of himself, is he attempting to handle? Have we proved that certain organic changes are at the bottom of this case, or have we here a bad coördination, which, if analysed so as to make clear to ourselves and to the patient what the organism is trying to accomplish, we can help him to replace by a new mechanism?"

In the last twenty years the functional nervous diseases have been studied from this new viewpoint, which might be called the dynamic one. It was soon discovered that the methods that were capable of profoundly modifying and even curing organic conditions had at best only a palliative effect on the functional conditions. Rest cures gave relief, but when the patient took up his life again, he began to use the same old mechanisms that had brought him to his retreat. Operations were performed that either patched or removed, but often with no result; baths, electricity, drugs, food—all stimulated or supplied energy, but still the mal-function went on. Soon it was obvious that the treatment that was necessary was one that aimed at understanding and modifying functions rather than structure. The bearing of all this is clear when one considers that the main aim of the treatment in the organic psychoses is to effect a structural change, while in the others it should be directed to establishing efficient functional habits.

As illustrations of these two groups, the individual suffering from paresis is a representative of the organic structural change, while the neurotic child belongs to the group of the functional derangements. Naturally no patient is ever entirely in the one or the other group, but must be viewed as belonging to one or the other to guide the main therapeutic effort.

The paretic patient with demonstrable organic change received a disproportionately large amount of attention, largely because his manifestations and the means and standards by which these could be investigated were capable of practically accurate measurement. The problem that then presented itself was comparatively simple, since a more or less definite entity could be dealt with. The neurotic child, on the other hand, has been, and to a very large extent is, a less tangible entity. The manifestations of its disorder are less marked by a lack of certain common qualities than by the improper functioning of apparently normal ones.

Society's lack of knowledge, therefore, led to a practical handling of the problem on a basis that was less scientific and more empirical. The child was labeled sullen, insubordinate, truant, and the manifestation was then treated in such a way as to make it least harmful to the community, irrespective of the result to the child. This tendency is still too much in evidence in our attitude toward those individuals, such as "recidivists," whose minds increasing investigation proves to be diseased. Society still reacts to the symptoms of a diseased mind, which many psychiatrists consider crime to be, and punishes the individual by sending him to prison. There is, fortunately, a strong movement in the direction of studying the individual as a whole and basing the disposition of the case on that, a movement that owes much to psychiatry.

As long as there are diseases with no structural changes in the brain, the organ that we premise to be for the integration of the highest psychic levels, we ought not to attempt to treat individuals by methods derived from the treatment of structural defects. In any other field of human activity in which the organic normality of the individual can be assumed to be proved by present-day standards, we do not use structural methods of modifying behavior, but rather dynamic ones. For instance, we naturally use what is called training, in teaching sports. The athlete's structure is not modified by operations, injections, and so forth. Why, then, use methods that modify structure in attempting to cure the neurotic child or adult, when structure, so far as we know at present, is normal and training methods are naturally indicated? It seems, therefore, that the problem of the maladjusted child, whose bodily structure cannot entirely explain the reason for its behavior, should be studied and treated from the viewpoint of training.

The conviction that more understanding of the problem was necessary had forced itself upon those who were in contact with the difficult child—those who knew by experience the bad results obtained by the methods in vogue. Knowledge gained from the study of the functional nervous diseases in adults has had an illuminating effect on the problems of education. It was observed that the early history of many individuals suffering from functional nervous disorders revealed that they in their time had been difficult, nervous children—the pupil who persistently played truant, lied, and stole, the child of bad habits, fears, and so forth; furthermore, the symptoms observed in adults were very often but the exaggerated behavior of the child. Such acts as skipping every other flagstone or stepping on every other crack in the sidewalk, or certain ceremonials on seeing redheads or white horses, are but the childish prototypes of the disease known as a compulsion neurosis. Fear of the dark or of cats, dogs, or strangers is the simple form of the same mechanism that later *may* become a phobia or morbid fear. If, therefore, the neurotic individual was to be healed at a stage where his modifiability was at its greatest and presented the greatest hope of a result, beneficial alike to himself and society, it should be done in childhood. One can easily see, therefore, the logical necessity for, and the welcoming approach to, a common ground of interest for pedagogue and psychiatrist.

In September, 1917, I undertook, at the Cornell Medical College Psychiatric Clinic, the examination of maladjusted children presenting problems of behavior either at home or at school which the parents or the social agencies supervising or having control of the children felt were beyond their understanding. The need for special work with this group of children had long been felt by the State Charities Aid Association of New York, especially in its Mental Hygiene Committee, and by the visiting teachers of the Public Education Association of New York.

It was thought best to conduct the examinations upon the principle that a few cases, thoroughly studied, would yield the best results, both for the children and for those interested in them. It was, therefore, decided to see only two new cases at each clinic day.

The plan was to have the cases brought to the clinic by the visiting teachers and social workers. They were to be children who presented some problem in social maladjustment. Cases in which the physical element was the main factor were referred to other departments of the clinic, but the child was retained by the clinic if this was only a contributing factor. In addition to these, cases were received from high schools and from the Placing-out Department of the State Charities Aid Association of New York.

A complete history of each child was required at its first appearance at the clinic. This history was obtained either by the social worker of the State Charities Aid Association or by the visiting teacher who brought the child. It was obtained by following a form that had been adapted from the one used by Dr. Healy[1]. The examination of the child was roughly divided into three parts—a psychiatric, a psychological, and a physical investigation. The psychiatric and in many cases the physical examination was carried out by the attending physician of the clinic. A personal interview of extended length was given the child, during which an attempt was made to gain his confidence by seeing the problem from his point of view. The intelligence tests were given by Miss Jessie Taft, the social-service director of the clinic. In cases where the physical examination demanded more expert attention, the case was referred to the appropriate department of the Cornell Dispensary. For the kindly coöperation of the physicians in other departments we wish at this place to make our acknowledgment and to express our thanks.

Parents were encouraged to come to the clinic to have the child's reactions explained and to afford to the clinic a better understanding of the home background. In some cases this visit by the parents was insisted upon as one of the therapeutic measures. The visiting teachers or social workers were given detailed explanations of the psychopathological mechanisms involved as a basis for their supervision and handling of the case. Tics, for instance, which are so annoying to parents and teachers, were explained as "spasmodic movements having a more or less purposive character." This disorder is definitely due to a weakening of nervous control and is most naturally explained as a dramatization of an instinctive tendency called into action by a shock or strain.

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[1] *The Individual Delinquent*, by William Healy. Boston: Little, Brown and Company, 1917. p. 48.

Thus the "eye tic" by which the child blinks or winks may be regarded as a symbol or dramatization of some protective tendency called into action by danger. The blinking is, therefore, an attempt not to see that which is irritating, painful, or dangerous. The form of the tic is that natural to an instinctive movement, but it depends for its activation essentially on a weakening of the normal nervous control. This latter is often brought about by malnutrition or illness, or it may be a congenital weakness.

Social agencies, such as trade schools, settlement houses, religious schools, gymnasia, volunteer workers, Big Brothers and Big Sisters, were freely used in the reëducation of the child, but chief dependence was placed upon the visiting teacher or person in charge.

A series of monthly conferences was held at the rooms of the Public Education Association, at which each worker made a report of all the cases under her care. Each case was then discussed as to the problems presented, the psychopathology, and the further treatment necessary.

Cases presenting special problems of great difficulty which forced the school to dismiss the child, or in which the home environment was particularly bad, were sent to Hartley House Farm at Towaco, New Jersey, under the supervision of Miss M. Moore, who is a graduate of Hunter College and has had considerable experience in experimental schools, and who has in addition the remarkable gift of a patient, constant, and friendly attitude, which does not change under the children's changing conduct. This trait in Miss Moore was used as a therapeutic agent which helped produce remarkable results in the children.

These were cases which, from the detailed study at the clinic and the history of the case, seemed to offer the possibility of being modified, not simply by a change of environment, but by the kind of understanding combined with a pedagogic training that Miss Moore possessed.

At this farm school the children were to be allowed as much liberty as was possible. There were to be few restraints and fewer punishments. As far as possible the children were to be taught by having the consequences of their acts brought to their attention rather than by being preached to before the act, or being prevented from performing an unsocial act. Each case was to receive individual attention. To this end and by reason of the limitations of space, the number of the children at the farm at any one time was limited to nine.

The country school which adjoined the farm was freely made use of for those children who had come from schools. The children's fear of incarceration was dispelled; they were told that they could return home whenever they pleased, that their stay at the farm was not an act of compulsion. If, however, they went home, it was with the understanding that they could not come back.

Each child had to care for its own bed and its own belongings. All assisted in the setting of the table, the serving of the food, the removal of the dishes to the kitchen, and the cleaning up of the dining room after the meal. Activities involving a certain degree of danger, such as climbing trees or fences, swinging very high, and so forth, were not prohibited. The usual squabbles and fisticuffs indulged in not only between the boys, but between the girls and the boys, were not stopped; but such incidents were taken up with the children only when the conflict did not in itself result in the adjustment of the relations between the children.

Long walks were taken into the woods and visits to the neighboring town were frequently made. As spring approached, garden plots were laid out. Each child was given one and encouraged by money prizes to keep its garden weeded and to cultivate the flowers and vegetables sown. It may be noted here that the money prizes—twenty-five cents a week—which the children were at liberty to spend in the neighboring village for whatever they chose to buy proved of little value as an incentive to gardening. The children were allowed and encouraged to perform manual tasks, such as chores about the farm and the small repairs to wood and stone fences, and so forth, that a farm continually needs.

With the advent of summer, Hartley House established its camp, and the crucial test in the adjustment of the boys to the normal city boys was then made by including the boys of our group in the regular camp group. This proved a very successful experiment, especially in the case of one boy who adjusted himself extremely well; in fact, he became a leader and a prime favorite with the camp leader and the boys.

Toward the end of August, it became necessary to place the girls in charge of a new supervisor, whose control of them and of herself was inadequate. A regression in their conduct took place, based no doubt upon the fact that the children realized that the person in charge had no real understanding of them, but attempted to exercise control by rigid standards and arbitrary discipline. The result was almost disastrous. The girls became incorrigible, disobedient, and the careful work of months seemed undone. As soon as Miss Moore returned, the children responded to her by becoming apparently normal individuals. This shows to what extent the neurotic child is so, not only by reason of its own make-up, but also as a reaction to an environment that is faulty. Further observation of the children for one year upon their return to their homes proved further that this regression was in large part a reaction to the person in charge. The house report in each case shows the child's conduct in September, 1919, to be a considerable improvement over the conduct in January, 1918.

The statistics that follow are taken from the records of 44 children, who were brought to the clinic between December 1, 1917, and July 1, 1918—a period of seven months.

The children varied in age from six to eighteen years, the greatest number—25, or 56.84 per cent—being from nine to thirteen years old; 10, or 22.70 per cent, were fourteen to eighteen years of age, and 9, or 20.45 per cent, were from six to eight years old. The intelligence quotients, by the Terman modification of the Binet-Simon test, of 23 ranged from 60 to 132; that is, 2 had an I. Q. of from 60 to 70, 10 from 70 to 80, 6 from 80 to 90, 1 from 90 to 100, 2 from 100 to 110, 1 from 110 to 120, and 1 had an I. Q. of 132. More than half were below 80 or in the retarded group. In 21 cases there was no record.

In 26 cases, the physical condition was not a factor in their maladjustment. Three were generally below par, with poor eyes, teeth, throats, malnutrition, and so forth. Four had chorea, and 1 choreiform movements. Three had defective teeth, and in 2 cases there was a history of rickets. There was 1 case of poor nutrition, 1 of astigmatism, 1 of a healed fractured skull; 1 had a nose and throat disorder, and 1 was anæmic.

As regards family history, 2 of the children were illegitimate, and alcoholism was recorded in the families of 11. One family had a record of insanity and of alcoholism, criminality, and epilepsy combined. In 8 families, one or more members were reported as neurotic or "nervous." The heredity was negative in 20 cases.

The races of the parents of these children were interesting from the standpoint of their wide distribution. Nineteen were American, 4 were German, 2 were of Austrian parentage; 1 parent in 1 family was Austrian Jewish, and 1 parent in 3 families was Russian Jewish; in 1 the parents were Roumanian Jewish, and American Jewish in another; in 1 they were Slavonic, in 1 Spanish-American; 2 were Irish, 2 Hungarian, 2 Russian, 1 Greek, 1 Italian, and 1 French-Russian Jewish.

Twenty-three of the 44 children attended school, ranging from the first to the seventh grade. Over 40 per cent of these were below grade. Of the remaining children, 12 were not in school, only one of them being of school age, and in 9 cases there was no school record. All of these 9 cases were children who were being transferred from one boarding home to another and at the time that they were brought to the clinic were not in school.

With most of the children, the prime factors of importance were the difficulties and bad conditions in the home. In 15 cases the trouble was largely due to lack of care and understanding and control at home—to impatience on the part of the parents and its reaction of antagonism and fear in the child. The changing environment necessitated by institutional life and life in foster homes caused much difficulty for a few children. In 3 cases poverty was the chief factor; in 2, inconsistent treatment of the child by those in authority; and in 1, a dirty, disorderly home. The environment apparently was not a demonstrable factor in 18 cases.

There was, naturally, a wide range of mental difficulties and social maladjustments. The chief complaint of the person who brought the child to the clinic is the basis for the statistical facts that are to follow. Among the symptoms for which the children were brought to the clinic, the most frequent were persistent stealing, lying, bed-wetting, and masturbation. Almost as frequently the complaint would be "nervousness," which on investigation would be found to cover one or more of the above symptoms and in addition rebelliousness, hate, or antagonism to one or both parents, poor attention or performance at school, truancy, irritability, moodiness, flights from home, lasting from hours to days, cruelty to other children and uncontrollable, violent rage. In not a single case was there only one symptom; usually three or four of the above symptoms would be present in a child. Eight of the children were truants who both lied and stole. Eight were backward in school, and were "nervous." Eight were excessive masturbators and chronic bed-wetters; 2 of these in addition lied and stole. One child lied, stole, had a violent temper, and was stubborn, antagonistic, and rebellious. Another thought that she was crazy—was sulky and very resistant and had an overdeveloped imagination.

Nearly half of the children (20) were brought to the clinic by visiting teachers. About a third (12) were sent by the State Charities Aid Association. Two were referred by Hartley House, 1 by the Russell Sage Foundation, and 1 was sent by a high-school teacher. In the histories there was a record of home supervision by visiting teachers in 10 cases and by social workers in 6.

One child was brought to the clinic five times, but most of the children—65 per cent—came only once. There is a record of improvement accomplished in behavior, in school work, or health in 16—or 50 per cent—of the non-farm cases. Twelve of the children were sent to the farm, of whom 9 were there for a long enough period (6 months) to feel the effect of what we were trying to do, and all 9 improved in some respects. The evidence for this is pragmatic, and for many people has the value of proof; it is rough, but intensely practical; it is the opinion of the parents, visiting teachers, teachers, and guardians of the children. Based upon their opinion and upon our observation, we have a record of improvement in 9 of the 12 farm cases, and in 16 of the remaining cases. We have counted as failures all children of which we have either a definite report of no improvement or no report whatever, due to the fact that they came but once to the clinic.

It might be well asked, "What does the psychiatrist mean by 'maladjusted children'?" Primarily, he means those whose conduct at home, at play, and in the school does not fit them into their environment. For this there may be either a physical cause, in which case it does not belong in our field, but to the realm of the pediatrist, a physician who treats the child from the standpoint of its physical make-up. Anything outside of this is the psychiatrist's field, even if there is an admixture of a physical cause, as is so often the case. Of course, no human being is, or ever will be, perfectly adjusted. Life, if viewed from the experimental angle, is a series of trials, errors, and solutions. Adjustment to life, and therefore success, is largely a matter of the number of trials we need before we find the solution, and maladjustment is largely the use of errors or false solutions as habitual methods. We have, therefore, a combination of the practical and the scientific method of expressing ourselves when we speak of showing an individual the errors of his ways. Of course, modern society is equipped with a large variety of means whereby the individual can make his trials and be shown his errors. But these means are often comparatively narrow in their range, their purpose being to fit the individual into a system rather than to teach him how to make use of that system. And the nervous child is such because he cannot fit himself into this system, either because of defects within himself or because society, as it is at present constituted, does not offer him sufficient means of expressing himself and he therefore uses those means which his prehistoric ancestors in their day were wont to use—namely, lying, stealing, deceit, and so forth.

The school's attitude in this problem, it seems to me, would change could a better understanding of human behavior, especially of child behavior, be given the teaching force. At present the consensus of opinion is that in too many of our schools the emphasis and attention is placed upon the system of education and not upon the child. Highly developed organizations are built up that are a glory to their originators and controllers, but are not entirely suitable as instruments for educating children. One of the results is the large number of children who, by this system's artificial standard, are classed as subnormal or neurotic. If the child does not fit into the system, he is badly mangled, as any unsuitable material would be in a machine. The change that is necessary is a change in emphasis. It is the duty of education to help the child, not to force him to fit into an educational system. And if the organization that is suitable for the average child does not fit a particular child, then provision should be made for adapting the system to the needs of the particular individual. It has been our sad experience that many teachers and principals have little use, time, or understanding for any child who in the slightest deviates from the dead average that is so suitable for the smooth running of a class or school and of such value in making what is called a "good showing" or "report." Obviously much is being done to rectify this state of affairs in the public schools, but of all the classes of maladjusted children, the emotionally maladjusted, to which class the neurotic child belongs, has received the least understanding and care. If the teaching force could be given a better understanding of the influence of instinct on human behavior, the difficult children would be more frequently referred to a psychiatrist.

To provide for the needs of the emotionally maladjusted child, the schools should establish small classes, including not more than ten, in which the neurotic child could be more carefully studied. The attitude of the school toward this class should not be that it is a punishment, but that it is an attempt to treat the child's behavior as a symptom. The child should be sent back to the regular classes just as soon as possible. The neurotic child feels himself as a thing apart, and some of his behavior is due to the attempt to get back into the group. It would be wise, therefore, to make the adjustment not only during school hours, but also outside of them. This can best be done by intensive individual study of the child in the home and school and by placing him in contact with somebody outside of the school, such as a visiting teacher, who thoroughly understands him, who he knows has his interest at heart. *It is to this influence on the part of a visiting teacher and psychiatric social worker that most of the improvement in our cases is ascribed.*

Our experience has impressed upon us a number of valuable facts which observers such as Dr. Macfie Campbell, Dr. L. Pierce Clark, and others in this field have mentioned before—first and foremost that there is a large class of children who belong neither to the feebleminded nor to the malignantly psychotic groups; and it is especially individuals of this group, called variously "nervous children" and "difficult children," that have the greatest possibilities in the way of adjustment to normality. Of course very careful intelligence, psychiatric, and physical examinations and tests must be made to determine to what group the child belongs.

But it is of extreme importance to emphasize the fact that no child should be arbitrarily classed as feebleminded on an intelligence test alone. Such a classification should depend upon a test that is in the nature of a continuous experiment, whose duration and whose administration under favorable environment shall be long enough to settle definitely this conclusion. This may take months. An illustration of this can be cited from our experience with one of the farm-school cases. Several psychological clinics had graded a child as feebleminded. She coöperated too poorly when tested at our clinic to make it possible to give her an intelligence quotient. In seven months her general improvement produced such a change that her intelligence quotient rose to over 80.

One of the strongest, if not the most important, factor in the improvement of the children is the human attitude of the person who undertakes their supervision. No training, no collegiate or post-graduate degree can take the place of this personality factor; formal education, it is true, may make it a better instrument for working with the child, but it is after all *the* agent or force that the child needs. It can probably best be defined as that objective attitude toward a child that is based on the observer's own habits of behavior consciously understood, guided, and, as far as possible, scientifically formulated. Without it, an individual in his relation to children is hopeless, nay, worse than hopeless; with it, a great many things are possible.

All who come into contact with the child have the duty of bringing *this factor* to the problem. It is not enough that one be well trained in the arts and sciences and especially medicine, but one must be able to give this intangible, illusive, tenuous factor called understanding a definite scientific formulation and background. It must show in everything he does, in every word and attitude toward the child. We have records that show that the improvement in the child dates from the day when he appreciated the fact that there was some one who was interested in him, not another agency that was against him.

There are many cases where sporadic visits would be of little avail—in cases of long standing, or where the family struggle for mere existence is such as to leave no place for the attention the nervous child needs. Here we feel that a place such as the farm school should be open for the nervous child. The two great objects that should be achieved at such a farm would be a maximum of healthful physical surroundings and the change in the emotional environment that would be the result of removing children from their homes and the city and placing them, temporarily, under the care of an individual such as Miss Moore. I can only repeat here that which I have said before—training is necessary to do the best kind of work, but it is not as essential as the other factor, that of understanding. It is understanding, controlled, guided, or directed by training, that is the very medicine these neurotic children need. The psychiatrist, the individual in charge, should keep both in mind.

If a child has once failed and has expressed that failure by using the method of adjustment which the race as a whole has outgrown, society has two methods of procedure open to it. It can either repress the individual, put him away, jail him, and so forth, or it can put him in an environment in which his lack will be understood and attempts will be made to develop him.

The segregation of children into institutions whose chief aim is segregation robs them of the chance to learn to adjust themselves. The spirit that deems that it is *they* who must rise unaided to majority standards is but the continuation of the very condition that led them into their abnormal behavior. Is it not rather society's duty, with insight and understanding of their levels of conduct, to lead them up to better ones?

The maladjustments that call for the psychiatrist's advice are those in which the behavior that brings about the maladjustment has crystallized into a rule of conduct, has become a habit or threatens to become one. Children should be brought to the psychiatrist whenever their habitual response is a maladjusted one, such as sulkiness, sullenness, laziness, lying, stealing, deceit, the tendency to remain apart, quarrelsomeness, and so forth.

SUMMARY.

The Children's Psychiatric Clinic has demonstrated not only the need for such a clinic, but also its usefulness. This is especially true in the case of neurotic children who show a wide variety of symptoms that can be understood and treated only by intensive study of each child and its home environment.

In addition to the correction of physical defects, there is usually necessary, not only a reëducation of the child, but also a change in the attitude of the home to the child. All this can often be accomplished through the clinic, with the necessary aid of the psychiatric social worker or the visiting teacher or any social worker who has an understanding of and a training in the principles of mental hygiene.

For those neurotic children for whom, either because of their inherent neurotic disposition or of irremedial home conditions, a continuance in the home offers very little hope of improvement, I urgently ask for the establishment of farm schools such as this paper outlines.

The resultant improvement in the behavior of the children, following the change in their personal and physical environment, appears at the end of two and one-half years to be permanent in approximately 50 per cent of the cases.

THE POSSIBILITIES OF A STATE SOCIETY FOR MENTAL HYGIENE*

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STATE societies for mental hygiene are of comparatively recent origin and as yet there seems to be no common agreement as to the exact functions they should perform. Indeed it is not rare to hear doubts expressed as to any justification for their development. In consequence, many of them lead a somewhat precarious existence. This state of affairs is certainly not due to any lack of constructive work to be done, but, in all probability, depends mainly upon a failure fully to grasp and clearly to formulate some plan of action.

A brief consideration of some features that serve to cloud the issue will therefore not be out of place. First, since the whole system of civilization is built upon intelligent activity and thus depends upon mental health, the subject is so large that it enters into every phase of social life and human relationship. Many of the problems with which it is concerned had necessarily been attacked by various agencies, often without appreciation of the fact that they were dealing with mental problems, long before the birth of the mental-hygiene society. Hence many fear duplication and waste of effort. This must be met by some clear definition of functions.

Secondly, there is a very prevalent belief that the term mental hygiene means only the treatment of insanity and feeblemindedness, which are two of the most striking examples of mental ill health. Furthermore, it is a fact that the state itself has assumed the responsibility of providing this care. Since the state can secure all the money it requires for these purposes by taxation, it is argued that there is no need for private assistance. But, it might be answered, even if these premises were correct, which they are not, before this money can be secured it is necessary that the taxpayer realize the importance and necessity of state care for the mentally diseased and the mentally deficient.

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* Read before the Indiana Society for Mental Hygiene, December 17, 1920.

Thirdly, the whole subject of mental activity has seemed so obscure and mysterious that efforts to deal with it as a concrete problem have to many appeared hopeless and to some even sacriligious. To suffer from a disordered mind is a stigma to be concealed and this stigma more or less spreads to those who concern themselves with it. This sentiment is still widespread and places enormous obstacles in the way of constructive work. While this is here cited as a probable factor in causing the difficulties peculiar to mental-hygiene work, it appeals to me as an especially cogent argument in favor of the development of mental-hygiene societies.

Such considerations lead me, before attempting to outline a program for the work of a state society for mental hygiene, to discuss in some detail the relations that exist between an organization of this kind and the state. First let us be clear as to the functions that the state has assumed in relation to mental health. In certain respects they are at variance with the general principles upon which our governments are organized. These principles lay particular emphasis upon self-determination, applied not only to nations, but also to individuals and communities. The state government concerns itself only with matters that affect all or a majority of its citizens and carefully avoids interference with purely local or individual affairs. Mr. Charles H. Thorne, Director of Public Welfare of Illinois, has well expressed this concept by saying that the functions of the state are "advisory and supervisory" except in regard to such matters as "can best be dealt with collectively." In regard to these latter the state assumes executive functions.

In this category most states have placed the care and treatment of the insane, feebleminded, criminal, and delinquent. Among the reasons leading to this conclusion may be mentioned the great variety of equipment and the special training of personnel requisite in order adequately to carry out this task. These entail a large overhead expense which, absolutely and not only relatively, is nearly as great for a small as for a large group of patients. Hence it is economy to centralize the work.

Further, it may be pointed out that, were each community to attempt the assumption of this burden, financially impossible except for the more populous centers, there would inevitably arise great inequality in the care provided in different parts of the state. Yet, from the very nature of the disorders to be treated, the patient is deprived of the liberty of choice and action. It is therefore necessary to adopt measures that will insure equality of opportunity, and for this central administration offers a more or less satisfactory solution.

Therefore the state has itself assumed the executive function of caring for those who are grossly disabled in mind. But this does not, at least primarily, include the broader problems of health *preservation*. It is only the treatment of those persons who have lost, or never possessed, mental health. Secondarily, it is true, because of the steadily increasing burden of providing for the consequences of loss of health, that there is a growing demand for measures to prevent, as well as to treat, mental disorder. All of this is included under the term mental hygiene. But the state, as yet, has done little more than undertake studies and investigations designed to determine how this may be accomplished.

We may next ask whether the work of putting preventive measures into effect belongs among those matters which are best dealt with collectively for the state as a whole. This, unlike the treatment of mental disease and deficiency, deals with individuals who are active and productive members of communities, capable of full citizenship. The purpose is to retain them in these surroundings and avoid the necessity for removal to treatment institutions and the loss to society thus incurred. Hence the work must be carried on in the community. The situation here is exactly comparable to that of the maintenance of public health in general, of which it is indeed only a part. Most states maintain a central department of health, but as a rule this acts, except in emergencies, mainly by giving expert advice and supervision, leaving the actual executive work to be performed by local agencies, county or municipal.

In addition to the work of prevention, and closely related to it, is the detection of evidences of ill health. This is universally left to local agencies and belongs essentially with the police powers of the community, although, except in emergency, it should not be handled by the police force as ordinarily understood. It strictly belongs in the police powers of a health department. The state assumes no responsibilities or jurisdiction until the existence of disease is established.

Thus far, however, we have considered only the grosser forms of mental disorder, those characterized by more or less actively antisocial behavior which renders those afflicted a source of danger to themselves or others. We have not touched upon a group of mental disorders—less menacing in appearance, but of immense importance to society—known technically as psychoneuroses, including hysteria, neurasthenia, psychasthenia, and other less well-defined types of psychopathic personality.

That this group is of large size is amply illustrated by experience gained in providing treatment and compensation for the disabilities of ex-service men and women. The nervous and mental cases constitute one of the largest groups of these disabilities, though as yet apparently it has not been determined what proportion belong in the category of the psychoneuroses. That this is many times larger than that of the insanities there is no question.

During the war there developed in the army a very large number of cases of psychoneurosis, often called "shell shock," and these figures might be quoted. But since they developed under the unusual circumstances of army life and battle conditions, and almost entirely disappeared with the cessation of these conditions, it seems preferable to cite the experiences of rehabilitation. Unfortunately we have no figures, but so important is the situation that the United States Public Health Service is finding it necessary to establish special organization and facilities for dealing with these cases. This may be considered as the first systematized effort to meet the problem of this particular type of mental disorder.

That the psychoneuroses constitute a big problem of civil life associated with great economic and industrial loss has been sufficiently emphasized by various writers in recent articles and need not further detain us. They are, especially if neglected or wrongly treated, often extremely chronic and difficult to handle. This is due to the fact that they represent essentially efforts on the part of the patient to escape from intolerable situations even if, as may be true, some inferiority in construction of the individual be requisite to bring about the adoption of such methods of reacting to intolerable situations. They are, to many physicians and others, very unattractive cases; the treatment requires exacting study and is often very tedious. In consequence these patients frequently drift from physician to physician or from clinic to clinic, tolerated rather than welcome and, if they have money, a natural prey for quacks and fakers of all kinds. Much is expended upon them in the form of charitable relief, and they are the source of untold misery and suffering to those naturally solicitous for their welfare or dependent upon them for subsistence.

Though it may be unnecessary, it is well to emphasize especially that these persons are neither insane nor feebleminded. Often, indeed, they are above the average in intelligence, though this is by no means essential.

Yet this problem, which I believe to be larger than that of tuberculosis, has received little or no consideration from any government agency, central or local, until now, when it has compelled attention from the army and the agencies dealing with disabilities of ex-service men and women.

The needs in the way of care and treatment differ from those for the insane and feebleminded by reason of the fact that prolonged hospitalization is not only as a rule unnecessary, but may be even highly detrimental. This was well shown by army experience, where it was found that the best results were obtained by efforts to build up morale and force the man to face the facts and meaning of his illness as near the fighting line as possible. Cases that were evacuated to base hospitals or sent home were by this step encouraged in a feeling of illness and inadequacy, with the consequence that many became confirmed invalids.

One of the essentials for successful treatment of these cases is early diagnosis. This has been affirmed so often for so many different forms of illness that the words have almost become a catch phrase. But it is especially important here, for the reason that methods of meeting situations that have once been adopted and have succeeded, in spite of the suffering they entail, in enabling a man to escape still more unpleasant responsibilities very easily tend to be repeated and to become habitual. Bad habits are proverbially difficult to break and this variety is no exception to the rule.

The purpose of a state society for mental hygiene, as usually stated in its constitution, is to promote measures for the preservation of mental health and the alleviation of the consequences of ill health. This assertion contains no suggestion of a desire or intention to undertake the task of carrying out these measures. That task, as in other matters of public health, these associations recognize to be a function of organized society itself. The mental-hygiene society is founded for the performance of educational or propagandist work, and this should be kept constantly in mind.

In the past there was great need for such popular education upon the necessity for improving facilities, provided by the state, for the treatment of mental disease and deficiency. While this need has not entirely disappeared, it has very greatly diminished, and to-day the old-time politically selected staffs of the institutions are rapidly being replaced by men and women chosen because of fitness and training for the particular work they have to do. The mental-hygiene society, consequently, now more often finds itself in the position of being called upon to assist in carrying out measures that have originated within the institutions than striving to impose much needed changes upon a group of indifferent or unwilling state officers. This change is well illustrated by the fact that state officials are frequently, as here in Indiana, active members of the state society for mental hygiene.

There is therefore need, if these societies are to justify their existence, for them to turn their attention to other fields still unworked, such as those already indicated of prevention and early diagnosis and the treatment of psychoneuroses. But it will probably at once be asked whether the necessary data upon which to base such work are at hand.

First with regard to prevention, which applies to psychoneuroses as well as to insanity and feeblemindedness. While it must be admitted that we still lack information as to the exact causes of many mental disorders, yet there is available much that has not as yet been put into practice. It would lead too far to attempt to detail this here, but a few illustrative examples in general terms may be cited. Popular education has already accomplished the removal of one potent source of these troubles by the passage of the Prohibition Amendment. Next it may be pointed out that approximately 15 per cent of all insanity and an entirely unknown proportion of other mental disorder and deficiency are due to infection with syphilis, a preventable disease.

The relation between various forms of bodily disease or defect—sense deprivation, disordered chemical activity within the body, and so forth—and mental disorders is becoming daily more clearly established. These bodily disturbances are capable of detection by proper methods of study and even if incapable of correction, as may be true, they may still form the basis for constructive efforts to educate and regulate the life of the individual in accordance with his handicaps and thus to diminish the mental stresses and difficulties which would otherwise result in breakdown.

Besides these more tangible bodily deficiences and diseases, there is also a large field of mental stresses based upon feelings of inadequacy or unsatisfied instinct—perhaps resulting from poor bodily construction of unknown kind, perhaps from the social milieu in which the individual happens to be placed—which are liable to produce intolerable situations and dissatisfactions and thus to result in definite mental disorder. These include problems of individual or family life and industrial and social conditions, many of which are capable of remedy or relief if only recognized with sufficient clearness.

When we turn to the question of the possibility of recognizing the danger or early signs of mental breakdown, before serious consequences have accrued, we find ourselves in even better case than with regard to the actual causes. Experience with the selective draft in the recent war has amply proved that, even with inadequate and hastily improvised means, it is possible to accomplish much. The process of weeding out the mentally unfit was probably not the only factor that contributed to the extraordinary freedom of our troops from mental disease and serious infractions of discipline, but it was undoubtedly a very large one.

Treatment of the psychoneuroses, if adopted early and in a systematic manner, also presents a most hopeful outlook.

This was evidenced in the acute disturbances incidental to the war; and while, because of the presence of more deeply constitutional types which were to a considerable degree excluded or early discharged from the army, we cannot expect the almost 100 per cent of recoveries there recorded, yet there is no doubt that early recognition will do much to minimize the failures and assist in restoring to some degree of usefulness many who will otherwise be but burdens on society.

The task here described so briefly and in such general terms is an enormous one which must inevitably extend over generations if it ever be entirely accomplished. This word of warning is necessary to avoid leaving with you the impression that I am offering a scheme to change the world overnight. Even the organization best calculated to accomplish the aims set forth has not yet been worked out and there will probably be many experiments and failures before this can be finally settled. For that reason it is best to avoid dogmatism and to leave to each group of workers the development of its own plans for work and the order of procedure. Yet there are some points upon which there will probably be fairly general agreement.

Preservation of mental health for the individual implies knowledge concerning the development of outlets for instinctive cravings within the limits set by a social manner of living and the selection of a mode of life appropriate to his particular abilities and handicaps. This covers the whole field of education, in the home and school, and enters into all human relationships—religion, marriage, occupation, and so forth. Obviously it extends far beyond the activities that fall properly in the sphere of a mental-hygiene society. This agency must coöperate with every other—school, church, or what not—already actively at work and endeavor to see that emphasis is laid upon the psychiatric problems involved. It will probably find that its own main service lies in undertaking to illustrate and drive home to all individuals the consequences of failure. This instruction and the illustrations must be varied so that selections can be made suitable for all kinds of audience of all ages and both sexes. While very material help in the collection of exhibits, literature, lecture topics, and so forth, can be secured from the National Committee, there is a very great advantage in preparing them from local sources. In this way the examples have an inescapable personal application and cannot be regarded with wonder as the failures of some neighboring community or state.

The preparation of such propaganda should, I believe, be one of the first efforts of a state society for mental hygiene, as it is with these weapons that it must fight to bring about more constructive results. Every use should be made of the state institutions for obtaining statistics and facts concerning the causation and treatment of disorders, not only because the society needs these materials, but also because it is a source of stimulus to the institution itself.

The first need for constructive work in connection with the aims described above is, I think, to bring about the establishment of dispensaries or clinics in all communities. These will serve to bring together the facilities for the study of individuals, the recognition of particular handicaps and dangers of breakdown, and thus provide a place to which all residents of the community may go for advice and such treatment as can be given in this form of service. The mental-health clinics should not be isolated, but should be part of a general clinic dealing with all forms of health preservation—child welfare, medical, surgical, eye, nose, throat, dental, and so forth.

Many, especially among the smaller communities, will probably find difficulty in securing physicians trained to carry on such work, particularly in regard to mental problems. Eventually this will doubtless be met by better teaching of these subjects in the medical schools. At present it may be suggested that the community can avail itself of the assistance of the staffs of neighboring state institutions, acting purely in a consulting capacity. Another plan would be the establishment of traveling clinics, still consultant in character, organized in connection with a central state or district agency of some kind.

The local clinics operated in the community should, I believe, be owned and maintained by the community itself through some local agency chosen and organized in accordance with conditions which there exist. They are not, and must not be considered as, charities, for they serve not only the individual, but also the needs of the whole community. No one is unaffected by the maladjustment of a member of the social group in which he lives.

Possibly, in addition to these local clinics, it will be found economical to develop regional clinics conveniently placed to serve a number of communities, having sufficient beds at their disposal and somewhat more elaborately equipped than are the local clinics, which will be maintained by the region they serve and to which would be sent for detailed study cases presenting special problems of unusual difficulty or importance. Many states are now developing, or have actually in operation, central psychiatric institutes supported by the state as a whole, which may well be considered as the most highly specialized and equipped of the whole system. In smaller states these would avoid the necessity for the intermediate regional clinic suggested above. Such institutes function as consultant rather than treatment hospitals and also provide training centers for physicians, nurses, and others and facilities for developing knowledge by research which may later be applied in the community clinics.

The work of the state society for mental hygiene in this connection is still educative and not executive. It should endeavor to develop in the community the realization of the needs and value of such work. Probably the best method of accomplishing this is by actual demonstration. After a campaign of education the society will establish and maintain temporarily a clinic for mental-health work and invite the community to use it. Usually a short demonstration is sufficient to create a popular demand for its continuation and it will not be long before it can be turned over to some local organization, either public or private. The society should be prepared to recommend some system of permanent organization which, by preference, should have close relations to the local health department.

The state hospitals and other institutions will usually be found not only willing, but anxious to coöperate in these ventures in a consultant capacity because they will also serve to assist the state in its own task. First, they provide a means of communication with the environment from which have come the patients the institution must treat; information from this source is often difficult to secure and yet may have a profound influence upon the character and duration of the treatment. Second, they afford a center through which supervision may be had over patients whom the hospital desires to return to social life without altogether discontinuing treatment. Finally if these clinics accomplish even a small degree of success in prevention, there will follow a corresponding relief to the overcrowding which is so prevalent in the institution and so detrimental to the performance of satisfactory work.

The program for active and practical work here outlined—which, unless one believes in paternalistic government, is distinctly outside the functions of the state government—requires the organization of an executive department in the mental-hygiene society. Truly constructive results will not be accomplished by meetings, important as they are for assisting in the planning of work and methods, such as this to-day. The work of these societies has been compared with a merchandising business, the article for sale being mental health. This audience has already purchased and probably all are stockholders. If the business is to succeed, we must advertise our wares among prospective customers who as yet know little of our goods.

In planning the organization, the size of which will determine the amount of work that should be undertaken at any one time, the main essential is to secure an executive head who possesses two qualifications. First he must be a good psychiatrist and second he must be a good salesman. It is preferable that he have an assistant to insure continuity of service. In addition there are needed clerical and advertising assistants and, for the clinic demonstrations, social-service nurses. The budget estimates must provide liberally for printing, illustrating, and traveling, with sufficient office space for headquarters, which need not be very large. As a rule local communities will provide space for temporary clinics so that the expenses here will be chiefly salaries and traveling.

In concluding this article, permit me to point out that I do not pretend to have covered the possible fields of activity or to have prescribed any particular course of action. My object will have been accomplished if I have, in any measure, succeeded in suggesting a line of argument and possible constructive activity which will lighten the difficulties experienced by so many of the state societies of mental hygiene in securing earnest attention and support.

MENTAL DISEASES IN TWELVE STATES, 1919

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THE data comprised in this study were obtained from the standard tables filled out by the 46 state hospitals of 12 states for the fiscal year ending in 1919. The state hospitals represented are distributed as follows: Arizona 1, Colorado 1, Iowa 4, Maine 2, Massachusetts 12, Nebraska 3, New Hampshire 1, New York 15, Rhode Island 1, South Carolina 1, South Dakota 1, Virginia 4.

Sets of tables were also received by the National Committee for Mental Hygiene from 24 state hospitals in 17 other states, but as complete data could not be obtained for any one of these states they were not included in this review.

This study is the first attempt to use for comparative purposes the results of the uniform system of statistics of mental diseases which was adopted by the American Medico-Psychological Association in 1917. This system and the coöperation of the superintendents of state hospitals have now made it possible to secure separate data concerning first admissions, readmissions, and transfers, and to compare the incidence of the various forms of mental disease in several states.

MOVEMENT OF PATIENTS

(See Table 1, page 365.)

At the beginning of the fiscal year of 1919, the hospitals comprised in this study had a total of 79,039 patients on their books; they received during the year 16,176 first admissions, 4,476 readmissions, and 1,660 transfers; they discharged 3,325 patients as recovered, 4,025 as improved, 2,041 as unimproved, 886 as without psychosis, and 1,745 by transfer to other institutions for mental diseases. The deaths numbered 9,309. The number of patients remaining on the books of the hospitals at the end of the fiscal year was 79,960, an increase of only 921, or 1.2 per cent, over the number at the beginning of the year. The high death rate during the fiscal year of 1918-1919, due to the influenza epidemic, was a factor in preventing a larger increase. Arizona, Rhode Island, and Virginia were the only states in which there was a decrease in patients under treatment during the year, although the increase was very small in several of the other states.

PSYCHOSES OF FIRST ADMISSIONS

(See Tables 2, 3 and 4, pages 368, 371, and 373.)

The first admissions to the state hospitals indicate to a fairly accurate degree the incidence of the more pronounced forms of mental disease. While some persons with mental disease are cared for at home and some are sent to private institutions, the total thus cared for is small compared with the number admitted to the state hospitals.

Table 2 shows the sex distribution of the first admissions of each clinical group. It is noteworthy that the total male first admissions exceed the female in every one of the 12 states except New Hampshire. In the separate groups of mental diseases, however, great variation in sex distribution is observed.

Clinical Groups in Which the Male First Admissions Notably Exceed the Female

	Males	Females
Traumatic	47	6
With cerebral arteriosclerosis	537	307
General paralysis	1,226	288
With cerebral syphilis	83	33
Alcoholic	572	131
Dementia praecox	2,230	2,050
With psychopathic personality	124	86

Clinical Groups in Which the Female First Admissions Notably Exceed the Male

	Males	Females
With pellagra	14	48
With other somatic diseases	262	415
Manic-depressive	922	1,347
Involution melancholia	123	330
Psychoneuroses and neuroses	99	173

From the foregoing comparisons, it is seen that the excess of males in the traumatic, syphilitic, and alcoholic groups is very marked. The greater exposure of man to accident is the obvious explanation of the excess of males in the traumatic group. It is also well known that men drink alcoholic liquors and contract syphilis to a far greater extent than do women. The excess of males in the dementia-praecox group is not so marked and with our present knowledge of the disorder cannot be satisfactorily explained.

The excess of women in the somatic-disease and manic-depressive groups is probably due in part to the difficulties connected with the bearing and rearing of children. The predominance of women in the involution-melancholia group indicates that in women the involutional period is accompanied by more profound mental and physical readjustments than in men.

In Table 3 are given the rates of first admissions in the principal clinical groups per 100,000 of the general population in the several states. Marked differences are found in the rates in the various states, especially in the larger groups of psychoses.

Comparison of Rates of First Admissions in Principal Clinical Groups per 100,000 of General Population in 12 States, 1919

State	All first admissions	Senile	With cerebral arterio-sclerosis	General paralysis	Alcoholic	Manic-depressive	Dementia praecox
Arizona	68.9	6.9	...	4.4	...	18.1	17.8
Colorado	47.2	8.4	1.2	6.7	0.2	5.6	11.3
Iowa	37.1	5.6	0.5	3.1	1.1	7.7	9.9
Maine	60.9	5.6	3.8	5.9	2.4	9.9	8.0
Massachusetts	98.5	7.8	7.6	6.5	7.8	7.1	25.8
Nebraska	39.7	6.8	0.5	3.5	0.5	7.2	11.4
New Hampshire	66.1	8.8	6.1	4.5	3.6	13.1	8.4
New York	67.5	6.8	3.9	8.7	2.8	9.9	18.8
Rhode Island	54.8	7.2	3.2	7.4	3.2	6.5	14.9
South Carolina	48.7	5.8	2.4	1.3	0.4	3.6	17.0
South Dakota	37.7	5.4	...	1.3	...	4.0	12.4
Virginia	57.3	7.5	0.4	1.8	1.3	15.0	12.4
Total	63.8	6.9	3.3	6.0	2.8	8.9	16.9

Chart 1

RATES OF FIRST ADMISSIONS WITH
GENERAL PARALYSIS IN 12 STATES, 1919

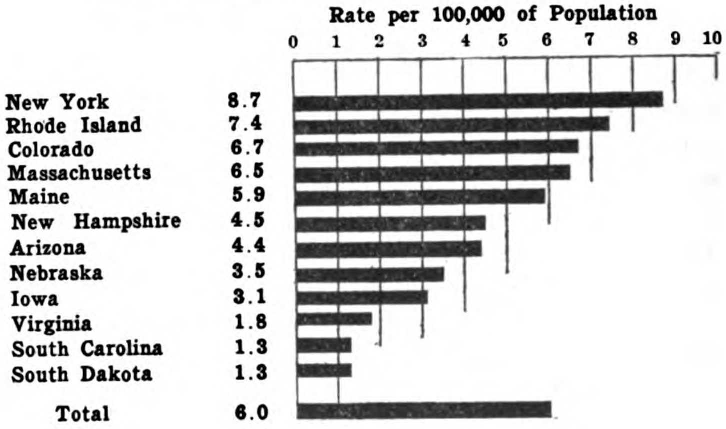
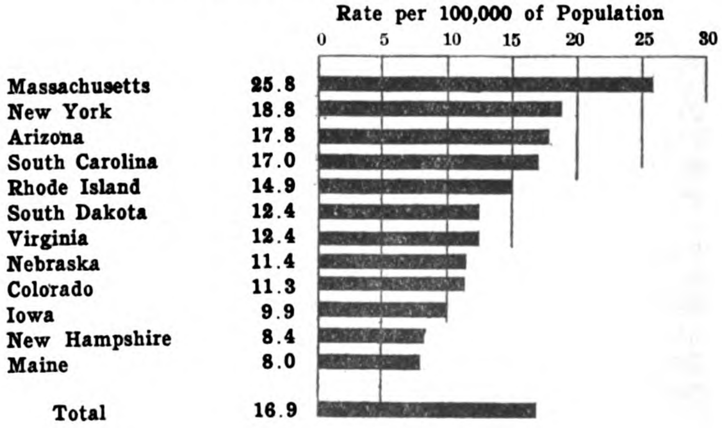


Chart 2

RATES OF FIRST ADMISSIONS WITH
DEMENTIA PRAECOX IN 12 STATES, 1919



From the foregoing summary, it is seen that Massachusetts has the highest rate of first admissions and the highest rate of alcoholic psychoses and of dementia praecox. New York has the highest rate of general paralysis and next to the highest rate of dementia praecox. South Carolina and Virginia have low rates of both alcoholic psychoses and general paralysis. Arizona, New Hampshire, and Virginia have high rates of manic-depressive psychoses. Iowa, Maine, and New Hampshire have low rates of dementia praecox.

The rates are influenced by many factors, among which may be mentioned the accessibility of state hospitals, environment, and the race and age distribution of the population. In Massachusetts, the high rate of first admissions and of alcoholic psychoses is due to a considerable extent to the great number of admissions to the Boston State Hospital, whose statistics included the Psychopathic Department. A large percentage of the admissions to that department had alcoholic psychoses.

Tablé 4 gives the per cent distribution of the principal psychoses in the several states. This table compares the relative prominence of the various forms of mental disease in the several states.

Per Cent Distribution of First Admissions in Principal Clinical Groups in 12 States, 1919

	Per Cent of Total Admissions in Each State					
State	Senile	With cerebral arteriosclerosis	General paralysis	Alcoholic	Manic-depressive	Dementia praecox
Arizona	10.2	...	6.5	...	26.9	26.4
Colorado	19.3	2.7	15.4	0.5	12.9	26.0
Iowa	15.1	1.4	8.4	2.9	20.7	26.8
Maine	10.9	7.4	11.4	4.6	19.3	15.5
Massachusetts	9.0	8.8	7.6	9.0	8.3	29.8
Nebraska	17.1	1.4	8.9	1.2	18.3	28.7
New Hampshire	14.9	10.3	7.6	6.1	22.1	14.1
New York	10.2	5.8	13.0	4.1	14.7	28.0
Rhode Island	13.6	6.0	13.9	6.0	12.3	28.2
South Carolina	14.0	5.8	3.0	0.9	8.6	40.7
South Dakota	14.6	...	3.4	...	10.7	33.5
Virginia	14.1	0.7	3.3	2.5	28.2	23.3
Total	11.4	5.5	9.9	4.6	14.8	28.0

Some of the marked variations shown in the above summary may be due to lack of uniformity in diagnosis, but in the main figures may be accepted at their face value.

ENVIRONMENT

(See Table 5, page 375.)

Table 5 gives the rates with respect to environment of first admissions in the principal clinical groups in 9 states. Of the ascertained cases, the rate of first admissions from urban districts was 69.9 per 100,000 of general population and from rural districts 37.9. The results in the several states vary widely, but with few exceptions the urban rates are higher than the rural. Some of the wide variations in the less populous states are due to the very small numbers dealt with. The rates in some of the principal psychoses were as follows:

Rates of First Admissions from Urban and Rural Districts

	RATES PER 100,000 OF POPULATION OF SAME ENVIRONMENT	
Psychoses	Urban	Rural
Senile	7.2	5.4
With cerebral arteriosclerosis	3.3	1.4
General paralysis	8.6	2.0
Alcoholic	2.8	0.6
Manic-depressive	10.5	6.8
Dementia praecox	19.4	9.5
All psychoses	68.2	36.0

The rate of general paralysis, according to these figures, is more than four times as high in cities as in rural districts. Alcoholic psychoses are also comparatively rare in rural districts.

MARITAL CONDITION

(See Table 6, page 379.)

Table 6 gives the marital condition of the first admissions to the state hospitals of the 12 states, classified by sex and psychoses. Of the 8,710 male first admissions, 4,099, or 47.1 per cent, were single; 3,389, or 38.9 per cent, were married; 805, or 9.2 per cent, were widowed; and 244, or 2.8 per cent, were separated or divorced. The marital condition of 173 male patients was unascertained. Of the 7,486 female first admissions, 2,416, or 32.3 per cent, were single; 3,378, or 45.1 per cent, were married; 1,335, or 17.8 per cent, were widowed; and 221, or 3.0 per cent, were separated or divorced. The marital condition of 136 female patients was unascertained.

Per Cent Distribution of Marital Condition of First Admissions in the Larger Clinical Groups

	PER CENT OF TOTAL OF EACH PSYCHOSIS							
	Single		Married		Widowed		Separated or divorced	
Psychoses	Males	Females	Males	Females	Males	Females	Males	Females
Senile	15.3	16.3	44.2	23.2	35.4	56.0	3.1	2.2
With cerebral arteriosclerosis	14.2	16.9	54.9	30.9	25.7	47.9	3.4	1.3
General paralysis	26.2	16.3	59.9	54.0	7.9	19.0	4.0	8.0
Alcoholic	44.4	11.5	41.1	59.5	8.7	24.4	4.7	3.9
Manic-depressive.	45.8	28.5	45.1	59.6	4.8	8.5	2.2	2.2
Dementia praecox	73.9	44.8	20.3	43.2	2.0	6.8	1.6	3.5

The differences in the percentages of males and females in the several groups are very striking. Women marry at an earlier age than men and have greater longevity. The onset of dementia praecox occurs earlier in life among males than among females. Many other more obscure factors operate to cause differences in the percentages in the several groups. The relatively high percentage of women with general paralysis in the separated or divorced group is noteworthy.

Use of Alcohol by First Admissions

(See Table 7, page 381.)

Table 7 gives a view of the extent of the use of alcohol by the patients of the various groups that entered the state hospitals for the first time in 1919. Nine states are included in the table. Of the 12,922 patients whose habits with respect to the use of alcohol were ascertained, 10,777, or 83.4 per cent, were abstinent or temperate and 2,145, or 16.6 per cent, were intemperate. To what extent the use of alcohol was a causative factor in the psychosis is not known except in the group with alcoholic psychoses, which comprised 667 patients, or 5.2 per cent of the first admissions whose alcoholic habits were ascertained. Excluding the group with alcoholic psychoses, 12.1 per cent were intemperate.

The percentages of ascertained cases in the several states that were intemperate users of alcohol were as follows:

State	Per cent of intemperate users of alcohol among first admissions
Colorado	10.8
Iowa	14.5
Maine	21.3
Massachusetts	19.4
New Hampshire	15.8
New York	16.4
Rhode Island	16.8
South Carolina	8.7
South Dakota	11.4
Total	16.6

READMISSIONS

(See Table 8, page 383.)

Table 8 shows the psychoses of the readmissions to the state hospitals of eleven states. Of the 4,212 readmissions classified in the table, 1,340, or 31.8 per cent, were manic-depressive, and 1,375, or 32.6 per cent, dementia praecox. The other forms of mental disease prominent among readmissions are general paralysis, alcoholic psychoses, involution melancholia, epileptic psychoses, psychoses with psychopathic personality, and psychoses with mental deficiency.

Per Cent Distribution of the Principal Psychoses of Readmissions

Psychoses	Per cent of total readmissions*
Senile	1.9
With cerebral arteriosclerosis	2.1
General paralysis	5.6
Alcoholic	4.2
Manic-depressive	33.0
Involution melancholia	2.8
Dementia praecox	33.8
Paranoia or paranoid conditions	1.7
Epileptic psychoses	2.5

* Readmissions without psychosis are excluded in computing percentages.

Psychoses	Per cent of total readmissions
Psychoneuroses and neuroses	1.8
With psychopathic personality	2.8
With mental deficiency	3.1
All other psychoses	4.7
Total	100.0

Arizona reports but 17 readmissions, Colorado but 20, and South Dakota but 9. With the accumulation of discharged cases in these states in succeeding years the readmissions will naturally increase.

Results of Treatment

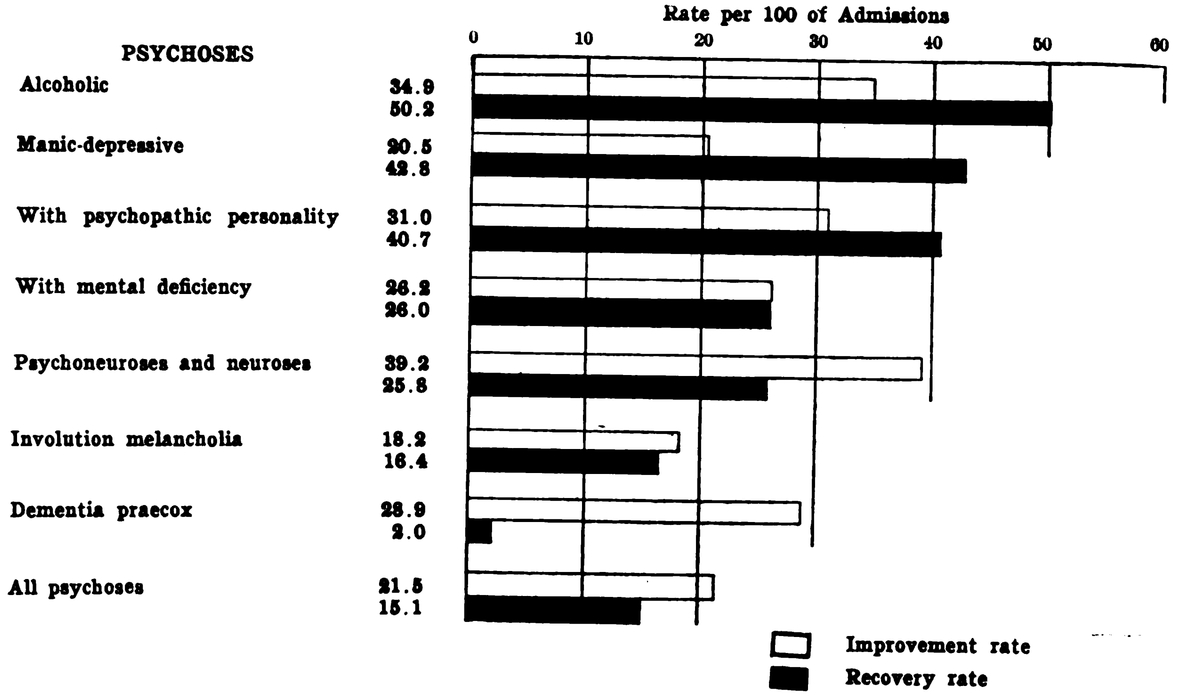
(See Table 9, page 384.)

The discharges from the state hospitals of 11 states classified with reference to form of mental disease on admission and condition on discharge are shown in Table 9. Marked differences appear in the rates of recovery and improvement in the various states. These rates were undoubtedly seriously affected by the influenza epidemic that occurred in the fall and winter of 1918-19.

Recovery and Improvement Rates in 10 States

	Per Cent of Total Admissions with Psychoses		
State	Discharged as recovered	Discharged as improved	Total
Arizona	16.5	42.2	58.7
Colorado	4.2	4.0	8.2
Maine	15.3	16.1	31.4
Massachusetts	9.6	22.5	32.1
Nebraska	4.1	20.3	24.4
New Hampshire	8.6	21.7	30.3
New York	18.2	21.5	39.7
Rhode Island	20.7	22.5	43.2
South Carolina	24.6	25.0	49.6
South Dakota	19.4	9.5	28.9
Total	15.1	21.5	36.6

Chart 3 RECOVERY AND IMPROVEMENT RATES IN PRINCIPAL GROUPS OF PSYCHOSES, STATE HOSPITALS OF TEN STATES, 1919



The rates of recovery and improvement in the various clinical groups are of much greater significance from the standpoint of prognosis. The number of cases in some of the groups is, however, too small to furnish an adequate basis for the computation of general rates. In considering recoveries in certain groups, such as psychoses with mental deficiency and with psychopathic personality, it must be remembered that the term "recovery" relates to the psychosis only.

Rates of Recovery and Improvement in the Principal Clinical Groups

	Per Cent of Total Admissions of Each Group		
Psychoses	Discharged as recovered	Discharged as improved	Total
Senile	0.3	7.0	7.3
With cerebral arteriosclerosis	2.1	10.1	12.2
General paralysis	....	8.9	8.9
Alcoholic	50.2	34.9	85.1
Manic-depressive	42.8	20.5	63.3
Involution melancholia	16.4	18.2	34.6
Dementia praecox	2.0	28.9	30.9
Paranoia or paranoid conditions	4.3	40.4	44.7
Epileptic psychoses	5.7	23.2	28.9
Psychoneuroses and neuroses	25.8	39.2	65.0
With psychopathic personality	40.7	31.0	71.7
With mental deficiency	26.0	26.2	52.2
All other psychoses	17.3	16.3	33.6
Total	15.1	21.5	36.6

DEATHS

(See Table 10, page 387.)

Table 10 gives the deaths of patients in state hospitals in 12 states, classified by sex and psychosis on admission. The general death rate per 1,000 patients under treatment, excluding transfers, was 93.4. As previously mentioned, this rate was made abnormally high by the influenza epidemic that occurred late in 1918. Marked differences are found in the death rates in the several states. The higher death rate among the males is due to the predominance of males in the paretic group.

Death Rates of Patients in 12 States

State	Death Rate per 1,000 Under Treatment		
	Males	Females	Total
Arizona	140.9	106.1	132.1
Colorado	113.8	94.3	105.6
Iowa	81.4	71.9	77.2
Maine	106.3	88.4	97.8
Massachusetts	94.7	76.9	85.8
Nebraska	83.1	70.6	77.6
New Hampshire	133.0	96.6	115.0
New York	101.7	91.5	96.4
Rhode Island	86.9	98.0	92.2
South Carolina	94.5	78.6	86.7
South Dakota	74.1	62.8	69.5
Virginia	107.0	117.1	111.9
Total	98.8	87.8	93.4

From the foregoing review it is seen that the facts relative to mental disease stand out much more clearly when data concerning separate diseases are presented than when all patients are grouped together in tables under the general heading "insane." The figures herein given indicate that each group of mental diseases presents its own problem and should receive separate consideration.

While it is regrettable that we are not yet able to compile complete data relative to mental diseases in all states of the Union, the progress that is being made in that direction is highly gratifying. In the review planned to cover the fiscal year 1920, it is hoped that complete data for several more states will be available, but in any event, there will be included in that review *all* hospitals submitting satisfactory reports.

Table 1—Movement of patients in state hospitals for mental diseases in twelve states, fiscal year ending in 1919

	TOTAL			ARIZONA			COLORADO			IOWA		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Insane patients on books at beginning of year	39,455	39,584	79,039	403	139	542	994	747	1,741	3,068	2,357	5,425
Admissions during year:												
First admissions	8,702	7,474	16,176	171	50	221	263	174	437	504	382	886
Readmissions	2,239	2,237	4,476	8	9	17	8	12	20	103	86	189
Transfers from other institutions for mental diseases	737	923	1,660	....	....	....	....	....	....	10	10	20
Total received during year	11,678	10,634	22,312	179	59	238	271	186	457	617	478	1,095
Total on books during year	51,133	50,218	101,351	582	198	780	1,265	933	2,198	3,685	2,835	6,520
Discharged from books during year:												
As recovered	1,654	1,671	3,325	31	7	38	10	8	18	127	125	252
As improved	2,082	1,943	4,025	78	19	97	7	10	17	39	12	51
As unimproved	1,172	869	2,041	13	2	15	2	....	2	16	13	29
As without psychosis	502	384	886	....	1	1	2	1	3	2	1	3
Transferred to other institutions for mental diseases	801	944	1,745	....	....	....	....	....	....	59	60	119
Otherwise discharged	42	18	60	....	....	....	....	....	....	26	18	44
Died during year	4,980	4,329	9,309	82	21	103	144	88	232	299	203	502
Total discharged, transferred and died during year	11,233	10,158	21,391	204	50	254	165	107	272	568	432	1,000
Insane patients remaining on books at end of institution year	39,900	40,060	79,960	378	148	526	1,100	826	1,926	3,117	2,403	5,520

Table 1—Movement of patients in state hospitals for mental diseases in twelve states, fiscal year ending in 1919—Continued

	MAINE			MASSACHUSETTS			NEBRASKA			NEW HAMPSHIRE		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Insane patients on books at beginning of year	995	923	1,918	8,092	8,403	16,495	1,495	1,166	2,661	683	675	1,358
Admissions during year:												
First admissions	259	207	466	1,985	1,761	3,746	288	223	511	144	148	292
Readmissions	74	57	131	801	689	1,490	46	27	73	45	36	81
Transfers from other institutions for mental diseases	11	6	17	157	242	399	1	1	2	...	...	...
Total received during year	344	270	614	2,943	2,692	5,635	335	251	586	189	184	373
Total on books during year	1,339	1,193	2,532	11,035	11,095	22,130	1,830	1,417	3,247	872	859	1,731
Discharged from books during year:												
As recovered	49	28	77	243	206	449	4	20	24	12	17	29
As improved	42	39	81	569	490	1,059	74	44	118	41	32	73
As unimproved	25	16	41	683	521	1,204	16	3	19	15	14	29
As without psychosis	32	13	45	281	261	542	1	2	3	12	17	29
Transferred to other institutions for mental diseases	12	4	16	186	254	440	2	1	3	...	...	...
Otherwise discharged	...	...	...	...	...	...	...	...	...	...	...	...
Died during year	141	105	246	1,030	835	1,865	152	100	252	116	83	199
Total discharged, transferred and died during year	301	205	506	2,992	2,567	5,559	249	170	419	196	163	359
Insane patients remaining on books at end of institution year	1,038	988	2,026	8,043	8,528	16,571	1,581	1,247	2,828	676	696	1,372

Table 1—Movement of patients in state hospitals for mental diseases in twelve states, fiscal year ending in 1919—Concluded

	NEW YORK			RHODE ISLAND			SOUTH CAROLINA			SOUTH DAKOTA			VIRGINIA		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Insane patients at beginning of year	18,492	20,280	38,772	891	809	1,700	1,110	1,078	2,188	635	442	1,077	2,597	2,565	5,162
Admissions during year:															
First admissions	3,650	3,279	6,929	174	154	328	415	397	812	142	96	238	707	603	1,310
Readmissions	876	1,042	1,918	40	37	77	105	102	207	6	3	9	127	137	264
Transfers from other institutions for mental diseases	551	659	1,210	.....	.....	.....	.....	.....	.....	.....	.....	.....	7	5	12
Total received during year	5,077	4,980	10,057	214	191	405	520	499	1,019	148	99	247	841	745	1,586
Total on books during year	23,569	25,260	48,829	1,105	1,000	2,105	1,630	1,577	3,207	783	541	1,324	3,438	3,310	6,748
Discharged from books during year:															
As recovered	748	852	1,600	43	38	81	107	108	215	27	20	47	253	242	495
As improved	925	969	1,894	53	35	88	105	114	219	12	11	23	137	168	305
As unimproved	287	216	503	29	19	48	38	25	63	4	13	17	44	27	71
As without psychosis	34	18	52	3	3	6	62	30	92	2	2	4	71	35	106
Transferred to other institutions for mental diseases	539	620	1,159	.....	.....	.....	.....	.....	.....	.....	.....	.....	3	5	8
Otherwise discharged	.....	.....	.....	.....	.....	.....	.....	.....	.....	16	.....	16	.....	.....	.....
Died during year	2,341	2,251	4,592	96	98	194	154	124	278	58	34	92	367	387	754
Total discharged, transferred and died during year	4,874	4,926	9,800	224	193	417	466	401	867	119	80	199	875	864	1,739
Insane patients remaining on books at end of institution year	18,695	20,334	39,029	881	807	1,688	1,164	1,176	2,340	664	461	1,125	2,563	2,446	5,009

Table 2—First admissions to state hospitals for mental diseases in twelve states, classified with reference to psychoses, 1919

PSYCHOSES	TOTAL			ARIZONA			COLORADO			IOWA		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Traumatic	47	6	53	....	....	....	....	1	1	2	....	2
Senile	841	901	1,742	19	3	22	42	36	78	79	54	133
With cerebral arteriosclerosis	537	307	844	....	....	....	7	4	11	11	1	12
General paralysis	1,226	288	1,514	12	2	14	52	10	62	66	8	74
With cerebral syphilis	83	33	116	2	....	2	1	....	1	6	....	6
With Huntington's chorea	8	11	19	....	....	....	....	....	....	....	2	2
With brain tumor	7	8	15	....	1	1	....	1	1	....	....	....
With other brain or nervous diseases	68	52	120	....	....	....	....	4	4	14	5	19
Alcoholic	572	131	703	....	....	....	2	....	2	25	1	26
Due to drugs and other exogenous toxins	31	36	67	5	2	7	....	2	2	1	2	3
With pellagra	14	48	62	....	1	1	....	....	....	....	....	....
With other somatic diseases	262	415	677	1	....	1	6	5	11	15	23	38
Manic-depressive	922	1,347	2,269	48	10	58	19	33	52	74	109	183
Involution melancholia	123	330	453	....	....	....	3	10	13	27	28	55
Dementia praecox	2,230	2,050	4,280	46	11	57	69	36	105	123	114	237
Paranoia or paranoid conditions	126	140	266	4	....	4	11	5	16	3	3	6
Epileptic psychoses	261	203	464	8	4	12	16	15	31	13	12	25
Psychoneuroses and neuroses	99	173	272	....	....	....	....	1	1	6	12	18
With psychopathic personality	124	86	210	1	2	3	....	....	....	13	....	13
With mental deficiency	268	240	508	21	3	24	7	6	13	20	5	25
Undiagnosed psychoses	335	305	640	....	10	10	....	....	....	5	2	7
Without psychosis	518	364	882	4	1	5	28	5	33	1	1	2
Total	8,702	7,474	16,176	171	50	221	263	174	437	504	382	886

Table 2—First admissions to state hospitals for mental diseases in twelve states, classified with reference to psychoses, 1919—Continued

PSYCHOSES	MAINE			MASSACHUSETTS			NEBRASKA			NEW HAMPSHIRE		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Traumatic	2	.....	2	15	2	17	6	2	8	1	.....	1
Senile	15	28	43	105	190	295	53	34	87	20	19	39
With cerebral arteriosclerosis	19	10	29	195	95	290	5	2	7	21	6	27
General paralysis	33	12	45	204	44	248	39	6	45	13	7	20
With cerebral syphilis	1	.....	1	27	14	41	5	3	8	.....	.....	.....
With Huntington's chorea	.....	.....	.....	2	4	6	.....	.....	.....	.....	.....	.....
With brain tumor	.....	.....	.....	6	3	9	.....	2	2	.....	.....	.....
With other brain or nervous diseases	1	.....	1	20	16	36	3	3	6	1	1	2
Alcoholic	17	1	18	241	54	295	6	.....	6	15	1	16
Due to drugs and other exogenous toxins	.....	.....	.....	2	1	3	1	.....	1	1	2	3
With pellagra	.....	.....	.....	.....	10	10	.....	.....	.....	.....	.....	.....
With other somatic diseases	12	11	23	58	79	137	5	7	12	4	10	14
Manic-depressive	35	41	76	99	172	271	35	58	93	22	36	58
Involution melancholia	2	17	19	19	55	74	3	1	4	3	8	11
Dementia praecox	35	26	61	479	501	980	78	68	146	15	22	37
Paranoia or paranoid conditions	5	7	12	23	47	70	4	3	7	1	5	6
Epileptic psychoses	13	10	23	37	33	70	13	13	26	2	3	5
Psychoneuroses and neuroses	3	5	8	29	58	87	11	9	20	4	5	9
With psychopathic personality	.....	2	2	17	9	26	7	5	12	.....	.....	.....
With mental deficiency	3	10	13	44	60	104	5	1	6	4	7	11
Undiagnosed psychoses	10	8	18	114	101	215	7	5	12	1	2	3
Without psychosis	53	19	72	249	213	462*	2	1	3	16	14	30
Total	259	207	466	1,985	1,761	3,746	288	223	511	144	148	292

* Includes 37 cases in which no diagnosis was made.

Table 2—First admissions to state hospitals for mental diseases in twelve states, classified with reference to psychoses, 1919—Concluded

PSYCHOSES	NEW YORK			RHODE ISLAND			SOUTH CAROLINA			SOUTH DAKOTA			VIRGINIA		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Traumatic	19	1	20	....	....	....	1	....	1	....	....	....	1	....	1
Senile	325	375	700	17	26	43	57	40	97	21	13	34	88	83	171
With cerebral arteriosclerosis	237	164	401	11	8	19	27	13	40	....	....	....	4	4	8
General paralysis	719	174	893	34	10	44	13	8	21	8	....	8	33	7	40
With cerebral syphilis	16	11	27	2	....	2	2	....	2	5	1	6	16	4	20
With Huntington's chorea	2	5	7	....	....	....	....	....	....	3	....	3	1	....	1
With brain tumor	1	1	2	....	....	....	....	....	....	....	....	....	....	....	....
With other brain or nervous diseases	16	17	33	2	1	3	1	....	1	3	....	3	7	5	12
Alcoholic	216	69	285	17	2	19	6	....	6	....	....	....	27	3	30
Due to drugs and other exogenous toxins	8	13	21	....	2	2	1	....	1	1	2	3	11	10	21
With pellagra	....	3	3	....	....	....	6	20	26	....	....	....	8	14	22
With other somatic diseases	77	211	288	3	6	9	12	6	18	19	18	37	50	39	89
Manic-depressive	358	654	1,012	17	22	39	28	32	60	14	11	25	173	169	342
Involution melancholia	56	205	261	....	....	....	3	3	6	3	2	5	4	1	5
Dementia praecox	1,051	873	1,924	48	41	89	120	163	283	47	31	78	119	164	283
Paranoia or paranoid conditions	63	49	112	....	....	....	2	3	5	2	1	3	8	17	25
Epileptic psychoses	97	82	179	6	6	12	21	7	28	6	5	11	29	13	42
Psychoneuroses and neuroses	36	62	98	1	3	4	1	6	7	2	5	7	6	7	13
With psychopathic personality	81	63	144	1	....	1	....	....	....	....	....	....	4	5	9
With mental deficiency	102	103	205	1	2	3	17	24	41	5	4	9	39	15	54
Undiagnosed psychoses	142	127	269	9	18	27	27	25	52	....	1	1	20	6	26
Without psychosis	28	17	45	5	7	12	70	47	117	3	2	5	59	37	96
Total	3,650	3,279	6,929	174	154	328	415	397	812	142	96	238	707	603	1,310

Table 3—Rates per 100,000 of general population of first admissions to state hospitals for mental diseases in twelve states, classified with reference to principal psychoses, 1919

PSYCHOSES	TOTAL		ARIZONA		COLORADO		IOWA		MAINE		MASSA-CHUSETTS	
	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000
Senile	1,742	6.9	22	6.9	78	8.4	133	5.6	43	5.6	295	7.8
With cerebral arteriosclerosis	844	3.3	......	......	11	1.2	12	0.5	29	3.8	290	7.6
General paralysis	1,514	6.0	14	4.4	62	6.7	74	3.1	45	5.9	248	6.5
Alcoholic	703	2.8	......	......	2	0.2	26	1.1	18	2.4	295	7.8
Manic-depressive	2,269	8.9	58	18.1	52	5.6	183	7.7	76	9.9	271	7.1
Involution melancholia	453	1.8	......	......	13	1.4	55	2.3	19	2.5	74	1.9
Dementia praecox	4,280	16.9	57	17.8	105	11.3	237	9.9	61	8.0	980	25.8
Paranoia or paranoid conditions	266	1.0	4	1.2	16	1.7	6	0.3	12	1.6	70	1.8
Epileptic psychoses	464	1.8	12	3.7	31	3.3	25	1.0	23	3.0	70	1.8
Psychoneuroses and neuroses	272	1.1	......	......	1	0.1	18	0.8	8	1.0	87	2.3
With psychopathic personality	210	0.8	3	0.9	......	......	13	0.5	2	0.3	26	0.7
With mental deficiency	508	2.0	24	7.5	13	1.4	25	1.0	13	1.7	104	2.7
All other psychoses	1,769	7.0	22	6.9	20	2.2	77	3.2	45	5.9	474	12.5
Without psychosis	882	3.5	5	1.6	33	3.6	2	0.1	72	9.4	462*	12.1
Total	16,176	63.8	221	68.9	437	47.2	886	37.1	466	60.9	3,746	98.5

* Includes 37 cases in which no diagnosis was made.

Table 3—Rates per 100,000 of general population of first admissions to state hospitals for mental diseases in twelve states, classified with reference to principal psychoses, 1919—Concluded

PSYCHOSES	NEBRASKA		NEW HAMPSHIRE		NEW YORK		RHODE ISLAND		SOUTH CAROLINA		SOUTH DAKOTA		VIRGINIA	
	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000	Total	Rate per 100,000
Senile	87	6.8	39	8.8	700	6.8	43	7.2	97	5.8	34	5.4	171	7.5
With cerebral arteriosclerosis	7	0.5	27	6.1	401	3.9	19	3.2	40	2.4	......	......	8	0.4
General paralysis	45	3.5	20	4.5	893	8.7	44	7.4	21	1.3	8	1.3	40	1.8
Alcoholic	6	0.5	16	3.6	285	2.8	19	3.2	6	0.4	......	......	30	1.3
Manic-depressive	93	7.2	58	13.1	1,012	9.9	39	6.5	60	3.6	25	4.0	342	15.0
Involution melancholia	4	0.3	11	2.5	261	2.5	......	......	6	0.4	5	0.8	5	0.2
Dementia praecox	146	11.4	37	8.4	1,924	18.8	89	14.9	283	17.0	78	12.4	283	12.4
Paranoia or paranoid conditions	7	0.5	6	1.4	112	1.1	......	......	5	0.3	3	0.5	25	1.1
Epileptic psychoses	26	2.0	5	1.1	179	1.7	12	2.0	28	1.7	11	1.7	42	1.8
Psychoneuroses and neuroses	20	1.6	9	2.0	98	1.0	4	0.7	7	0.4	7	1.1	13	0.6
With psychopathic personality	12	0.9	......	......	144	1.4	1	0.2	......	......	......	......	9	0.4
With mental deficiency	6	0.5	11	2.5	205	2.0	3	0.5	41	2.5	9	1.4	54	2.4
All other psychoses	49	3.8	23	5.2	670	6.5	43	7.2	101	6.1	53	8.4	192	8.4
Without psychosis	3	0.2	30	6.8	45	0.4	12	2.0	117	7.0	5	0.8	96	4.2
Total	511	39.7	292	66.1	6,929	67.5	328	54.8	812	48.7	238	37.7	1,310	57.3

Table 4—Per cent distribution of principal psychoses among first admissions to state hospitals for mental diseases in twelve states, 1919*

PSYCHOSES	TOTAL		ARIZONA		COLORADO		IOWA		MAINE		MASSA-CHUSETTS	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Senile	1,742	11.4	22	10.2	78	19.3	133	15.1	43	10.9	295	9.0
With cerebral arteriosclerosis	844	5.5	.....	.....	11	2.7	12	1.4	29	7.4	290	8.8
General paralysis	1,514	9.9	14	6.5	62	15.4	74	8.4	45	11.4	248	7.6
Alcoholic	703	4.6	.....	.....	2	0.5	26	2.9	18	4.6	295	9.0
Manic-depressive	2,269	14.8	58	26.9	52	12.9	183	20.7	76	19.3	271	8.3
Involution melancholia	453	3.0	.....	.....	13	3.2	55	6.2	19	4.8	74	2.3
Dementia praecox	4,280	28.0	57	26.4	105	26.0	237	26.8	61	15.5	980	29.8
Paranoia or paranoid conditions	266	1.7	4	1.9	16	4.0	6	0.7	12	3.0	70	2.1
Epileptic psychoses	464	3.0	12	5.6	31	7.8	25	2.8	23	5.8	70	2.1
Psychoneuroses and neuroses	272	1.8	.....	.....	1	0.2	18	2.0	8	2.0	87	2.6
With psychopathic personality	210	1.4	3	1.4	.....	.....	13	1.5	2	0.5	26	0.8
With mental deficiency	508	3.3	24	11.1	13	3.2	25	2.8	13	3.3	104	3.2
All other psychoses	1,769	11.6	22	10.2	20	5.0	77	8.7	45	11.4	474	14.4
Total psychoses	15,294	100.0	216	100.0	404	100.0	884	100.0	394	100.0	3,284	100.0
Without psychosis	882	.....	5	.....	33	.....	2	.....	72	.....	462†	.....
Total	16,176	.....	221	.....	437	.....	886	.....	466	.....	3,746	.....

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* First admissions without psychosis are excluded in computing percentages.

† Includes 37 cases in which no diagnosis was made.

Table 4—Per cent distribution of principal psychoses among first admissions to state hospitals for mental diseases in twelve states, 1919—Concluded*

Psychoses	Nebraska		New Hampshire		New York		Rhode Island		South Carolina		South Dakota		Virginia	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Senile	87	17.1	39	14.9	700	10.2	43	13.6	97	14.0	34	14.6	171	14.1
With cerebral arteriosclerosis	7	1.4	27	10.3	401	5.8	19	6.0	40	5.8	......	......	8	0.7
General paralysis	45	8.9	20	7.6	893	13.0	44	13.9	21	3.0	8	3.4	40	3.3
Alcoholic	6	1.2	16	6.1	285	4.1	19	6.0	6	0.9	......	......	30	2.5
Manic-depressive	93	18.3	58	22.1	1,012	14.7	39	12.3	60	8.6	25	10.7	342	28.2
Involution melancholia	4	0.8	11	4.2	261	3.8	......	......	6	0.9	5	2.1	5	0.4
Dementia praecox	146	28.7	37	14.1	1,924	28.0	89	28.2	283	40.7	78	33.5	283	23.3
Paranoia or paranoid conditions	7	1.4	6	2.3	112	1.6	......	......	5	0.7	3	1.3	25	2.1
Epileptic psychoses	26	5.1	5	1.9	179	2.6	12	3.8	28	4.0	11	4.7	42	3.5
Psychoneuroses and neuroses	20	3.9	9	3.4	98	1.4	4	1.3	7	1.0	7	3.0	13	1.1
With psychopathic personality	12	2.4	......	......	144	2.1	1	0.3	......	......	......	......	9	0.7
With mental deficiency	6	1.2	11	4.2	205	3.0	3	1.0	41	5.9	9	3.9	54	4.4
All other psychoses	49	9.6	23	8.8	670	9.7	43	13.6	101	14.5	53	22.8	192	15.8
Total psychoses	508	100.0	262	100.0	6,884	100.0	316	100.0	695	100.0	233	100.0	1,214	100.0
Without psychosis	3	......	30	......	45	......	12	......	117	......	5	......	96	......
Total	511	......	292	......	6,929	......	328	......	812	......	238	......	1,310	......

* First admissions without psychosis are excluded in computing percentages.

Table 5—Environment of first admissions to state hospitals for mental diseases in nine states, classified with reference to principal psychoses and compared with general population, 1919*

PSYCHOSES	TOTAL				COLORADO			
	URBAN		RURAL		URBAN		RURAL	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Senile	873	7.2	468	5.4	47	10.5	27	5.7
With cerebral arteriosclerosis	403	3.3	118	1.4	5	1.1	4	0.8
General paralysis	1,041	8.6	178	2.0	33	7.4	28	5.9
Alcoholic	333	2.8	56	0.6	1	0.2	1	0.2
Manic-depressive	1,271	10.5	598	6.8	26	5.8	35	7.3
Involution melancholia	253	2.1	109	1.2	3	0.7	8	1.7
Dementia praecox	2,341	19.4	826	9.5	63	14.1	45	9.4
Paranoia or paranoid conditions	131	1.1	49	0.6	7	1.6	4	0.8
Epileptic psychoses	231	1.9	144	1.6	15	3.3	16	3.4
Psychoneuroses and neuroses	128	1.1	45	0.5	1	0.2	......	......
With psychopathic personality	136	1.1	44	0.5	......	......	......	......
With mental deficiency	224	1.9	139	1.6	5	1.1	6	1.3
All other psychoses	871	7.2	366	4.2	13	2.9	6	1.3
Without psychosis	203	1.7	174	2.0	12	2.7	17	3.6
Total	8,439	69.9	3,314	37.9	231	51.5	197	41.3

* One hundred and eighty-four patients whose environment was unascertained were excluded.

Table 5—Environment of first admissions to state hospitals for mental diseases in nine states, classified with reference to principal psychoses and compared with general population, 1919—Continued*

Psychoses	Iowa				Maine			
	Urban		Rural		Urban		Rural	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Senile	81	9.5	45	2.9	22	7.4	21	4.5
With cerebral arteriosclerosis	6	0.7	6	0.4	12	4.1	17	3.6
General paralysis	59	6.9	14	0.9	26	8.8	19	4.0
Alcoholic	14	1.6	9	0.6	14	4.7	4	0.9
Manic-depressive	101	11.8	76	5.0	38	12.8	38	8.1
Involution melancholia	32	3.7	21	1.4	5	1.7	14	3.0
Dementia praecox	130	15.2	95	6.2	40	13.5	21	4.5
Paranoia or paranoid conditions	3	0.4	2	0.1	2	0.7	10	2.1
Epileptic psychoses	15	1.8	9	0.6	12	4.1	11	2.3
Psychoneuroses and neuroses	10	1.2	7	0.5	5	1.7	3	0.6
With psychopathic personality	8	0.9	5	0.3	1	0.3	1	0.2
With mental deficiency	13	1.5	12	0.8	8	2.7	5	1.1
All other psychoses	44	5.1	33	2.2	18	6.1	27	5.7
Without psychosis	1	0.1	1	0.1	36	12.2	36	7.7
Total	517	60.4	335	21.9	239	80.8	227	48.3

* One hundred and eighty-four patients whose environment was unascertained were excluded.

Table 5—Environment of first admissions to state hospitals for mental diseases in nine states, classified with reference to principal psychoses and compared with general population, 1919—Continued*

PSYCHOSES	NEBRASKA				NEW YORK				RHODE ISLAND			
	URBAN		RURAL		URBAN		RURAL		URBAN		RURAL	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Senile	29	7.3	40	4.5	551	6.5	136	7.5	39	6.7	4	25.8
With cerebral arteriosclerosis	2	0.5	4	0.4	338	4.0	61	3.4	19	3.3	.....	.....
General paralysis	26	6.6	16	1.8	812	9.6	75	4.1	43	7.4	1	6.5
Alcoholic	6	1.5	.....	.....	257	3.0	28	1.5	18	3.1	1	6.5
Manic-depressive	44	11.1	41	4.6	875	10.4	131	7.2	39	6.7	.....	.....
Involution melancholia	.....	.....	4	0.4	209	2.5	50	2.8	.....	.....	.....	.....
Dementia praecox	72	18.2	64	7.2	1,738	20.6	177	9.8	85	14.6	4	25.8
Paranoia or paranoid conditions	5	1.3	2	0.2	95	1.1	17	0.9	.....	.....	.....	.....
Epileptic psychoses	9	2.3	16	1.8	147	1.7	32	1.8	12	2.1	.....	.....
Psychoneuroses and neuroses	8	2.0	10	1.1	89	1.1	9	0.5	4	0.7	.....	.....
With psychopathic personality	5	1.3	6	0.7	118	1.4	26	1.4	1	0.2	.....	.....
With mental deficiency	1	0.3	3	0.3	172	2.0	32	1.8	3	0.5	.....	.....
All other psychoses	21	5.3	23	2.6	589	7.0	76	4.2	41	7.0	2	12.9
Without psychosis	2	0.5	1	0.1	32	0.4	13	0.7	12	2.1	.....	.....
Total	230	58.1	230	25.8	6,022	71.3	863	47.7	316	54.2	12	77.5

* One hundred and eighty-four patients whose environment was unascertained were excluded.

Table 5—Environment of first admissions to state hospitals for mental diseases in nine states, classified with reference to principal psychoses and compared with general population, 1919—Concluded*

Psychoses	South Carolina				South Dakota				Virginia			
	URBAN		RURAL		URBAN		RURAL		URBAN		RURAL	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Senile	22	7.7	72	5.2	18	18.1	16	3.0	64	9.8	107	6.6
With cerebral arteriosclerosis	18	6.3	21	1.5	...	...	...	...	3	0.5	5	0.3
General paralysis	9	3.1	10	0.7	5	5.0	3	0.6	28	4.3	12	0.7
Alcoholic	3	1.0	3	0.2	...	...	...	...	20	3.1	10	0.6
Manic-depressive	7	2.4	52	3.8	16	16.1	9	1.7	125	19.1	216	13.2
Involution melancholia	1	0.3	5	0.4	2	2.0	3	0.6	1	0.2	4	0.2
Dementia praecox	58	20.2	214	15.5	37	37.2	41	7.7	118	18.0	165	10.1
Paranoia or paranoid conditions	3	1.0	2	0.1	1	1.0	2	0.4	15	2.3	10	0.6
Epileptic psychoses	1	0.3	27	2.0	7	7.0	4	0.8	13	2.0	29	1.8
Psychoneuroses and neuroses	2	0.7	5	0.4	6	6.0	1	0.2	3	0.5	10	0.6
With psychopathic personality	...	...	...	...	...	...	...	...	3	0.5	6	0.4
With mental deficiency	3	1.0	37	2.7	5	5.0	4	0.8	14	2.1	40	2.5
All other psychoses	30	10.5	69	5.0	27	27.2	26	4.9	88	13.5	104	6.4
Without psychosis	46	16.0	68	4.9	3	3.0	2	0.4	59	9.0	36	2.2
Total	203	70.7	585	42.4	127	127.8	111	20.9	554	84.7	754	46.3

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* One hundred and eighty-four patients whose environment was unascertained were excluded.

Table 6—Per cent distribution of first admissions to state hospitals for mental diseases in twelve states for the fiscal year 1919, classified according to marital condition in the principal psychoses

PSYCHOSES	TOTAL				SINGLE				MARRIED			
	MALES		FEMALES		MALES		FEMALES		MALES		FEMALES	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Senile	841	100.0	901	100.0	129	15.3	147	16.3	372	44.2	209	23.2
With cerebral arteriosclerosis	537	100.0	307	100.0	76	14.2	52	16.9	295	54.9	95	30.9
General paralysis	1,227	100.0	289	100.0	321	26.2	47	16.3	735	59.9	156	54.0
Alcoholic	572	100.0	131	100.0	254	44.4	15	11.5	235	41.1	78	59.5
Manic-depressive	926	100.0	1,354	100.0	424	45.8	386	28.5	418	45.1	807	59.6
Involution melancholia	123	100.0	330	100.0	26	21.1	59	17.9	80	65.0	177	53.6
Dementia praecox	2,232	100.0	2,053	100.0	1,649	73.9	919	44.8	454	20.3	887	43.2
Paranoia or paranoid conditions	126	100.0	140	100.0	45	35.7	36	25.7	61	48.4	65	46.4
Epileptic psychoses	262	100.0	204	100.0	177	67.6	101	49.5	60	22.9	65	31.9
Psychoneuroses and neuroses	99	100.0	173	100.0	50	50.5	64	37.0	44	44.4	84	48.6
With psychopathic personality	124	100.0	86	100.0	79	63.7	50	58.1	37	29.8	26	30.2
With mental deficiency	268	100.0	240	100.0	235	87.7	159	66.3	24	9.0	60	25.0
All other psychoses	855	100.0	914	100.0	328	38.4	203	22.2	415	48.5	534	58.4
Total psychoses	8,192	100.0	7,122	100.0	3,793	46.3	2,238	31.4	3,230	39.4	3,243	45.5
Without psychosis	518	100.0	364	100.0	306	59.1	178	48.9	159	30.7	135	37.1
Total	8,710	100.0	7,486	100.0	4,099	47.1	2,416	32.3	3,389	38.9	3,378	45.1

Table 6—Per cent distribution of first admissions to state hospitals for mental diseases in twelve states for the fiscal year 1919, classified according to marital condition in the principal psychoses—Concluded

PSYCHOSES	WIDOWED				SEPARATED				DIVORCED				UNASCERTAINED			
	MALES		FEMALES		MALES		FEMALES		MALES		FEMALES		MALES		FEMALES	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Senile	298	35.4	505	56.0	15	1.8	11	1.2	11	1.3	9	1.0	16	1.9	20	2.2
With cerebral arteriosclerosis	138	25.7	147	47.9	10	1.9	4	1.3	8	1.5	.....	.....	10	1.9	9	2.9
General paralysis	97	7.9	55	19.0	27	2.2	11	3.8	22	1.8	12	4.2	25	2.0	8	2.8
Alcoholic	50	8.7	32	24.4	12	2.1	4	3.1	15	2.6	1	0.8	6	1.0	1	0.8
Manic-depressive	44	4.8	115	8.5	14	1.5	20	1.5	6	0.7	10	0.7	20	2.2	16	1.2
Involution melancholia	14	11.4	81	24.5	2	1.6	6	1.8	1	0.8	3	0.9	.....	.....	4	1.2
Dementia praecox	44	2.0	139	6.8	23	1.0	41	2.0	14	0.6	30	1.5	48	2.2	37	1.8
Paranoia or paranoid conditions	8	6.3	31	22.1	3	2.4	6	4.3	4	3.2	1	0.7	5	4.0	1	0.7
Epileptic psychoses	12	4.6	25	12.3	5	1.9	4	2.0	3	1.1	1	0.5	5	1.9	8	3.9
Psychoneuroses and neuroses	2	2.0	16	9.2	1	1.0	5	2.9	1	1.0	3	1.7	1	1.0	1	0.6
With psychopathic personality	3	2.4	9	10.5	3	2.4	1	1.2	2	1.6	.....	.....	.....	.....	.....	.....
With mental deficiency	5	1.9	12	5.0	.....	.....	4	1.7	1	0.4	3	1.3	3	1.1	2	0.8
All other psychoses	66	7.7	135	14.8	11	1.3	8	0.9	11	1.3	10	1.1	24	2.8	24	2.6
Total psychoses	781	9.5	1,302	18.3	126	1.5	125	1.8	99	1.2	83	1.2	163	2.0	131	1.8
Without psychosis	24	4.6	33	9.1	7	1.4	4	1.1	12	2.3	9	2.5	10	1.9	5	1.4
Total	805	9.2	1,335	17.8	133	1.5	129	1.7	111	1.3	92	1.2	173	2.0	136	1.8

Table 7—Use of alcohol by first admissions to state hospitals for mental diseases in nine states, classified with reference to principal psychoses, 1919

Psychoses	Total			Colorado*			Iowa			Maine			Massachusetts		
	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained
Senile	1,117	130	214	63	9	6	93	12	28	38	1	4	234	24	36
With cerebral arteriosclerosis	633	105	91	8	1	2	7	......	5	21	6	2	234	36	20
General paralysis	941	316	159	38	15	11	47	15	12	25	18	2	182	54	12
Alcoholic	......	667	......	......	2	......	......	26	......	......	18	......	......	295	......
Manic-depressive	1,555	114	118	57	1	5	143	15	25	67	8	1	240	20	11
Involution melancholia	402	21	21	12	1	......	47	4	4	19	......	......	67	1	6
Dementia praecox	3,106	331	361	83	8	19	175	23	39	45	6	10	827	90	62
Paranoia or paranoid conditions	191	26	14	15	1	......	4	......	2	8	1	3	60	7	4
Epileptic psychoses	324	38	24	28	1	4	18	1	6	21	2	......	60	10	......
Psychoneuroses and neuroses	225	10	4	1	......	......	17	1	......	8	......	......	85	1	1
With psychopathic personality	149	27	10	......	......	......	9	1	3	1	1	......	19	6	1
With mental deficiency	343	43	41	13	......	......	17	......	8	12	......	1	89	13	5
All other psychoses	1,190	175	142	16	3	1	59	10	8	32	11	2	382	57	35
Without psychosis†	601	142	33	31	2	......	1	......	1	46	21	5	371	73	16
Total	10,777	2,145	1,232	365	44	48	637	108	141	343	93	30	2,850	687	209

* Includes 20 readmissions

† Includes 37 cases in Massachusetts in which no diagnosis was made.

Table 7—Use of alcohol by first admissions to state hospitals for mental diseases in nine states, classified with reference to principal psychoses, 1919—Concluded

PSYCHOSES	NEW HAMPSHIRE			NEW YORK			RHODE ISLAND			SOUTH CAROLINA			SOUTH DAKOTA		
	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained	Abstinent or temperate	Intemperate	Unascertained
Senile	30	4	5	504	76	120	39	......	4	86	......	11	30	4	......
With cerebral arteriosclerosis	15	3	9	300	55	46	15	1	3	33	3	4	......	......	......
General paralysis	14	3	2	587	191	115	28	13	3	15	4	2	5	3	......
Alcoholic	......	16	......	......	285	......	......	19	......	......	6	......	......	......	......
Manic-depressive	45	2	11	893	62	57	34	2	3	54	1	5	22	3	......
Involution melancholia	8	1	2	239	14	8	......	......	......	5	......	1	5	......	......
Dementia praecox	28	1	8	1,559	183	182	78	6	5	237	10	36	74	4	......
Paranoia or paranoid conditions	5	......	1	93	16	3	......	......	......	4	......	1	2	1	......
Epileptic psychoses	4	1	......	149	18	12	10	1	1	26	1	1	8	3	......
Psychoneuroses and neuroses	8	1	......	89	6	3	4	......	......	6	1	......	7	......	......
With psychopathic personality	......	......	......	119	19	6	1	......	......	......	......	......	......	......	......
With mental deficiency	7	2	2	160	25	20	2	1	......	34	2	5	9	......	......
All other psychoses	16	......	8	526	76	68	34	4	5	80	7	14	45	7	1
Without psychosis	22	4	4	37	8	......	8	4	......	83	28	6	2	2	1
Total	202	38	52	5,255	1,034	640	253	51	24	663	63	86	209	27	2

Table 8—Readmissions to state hospitals for mental diseases in eleven states, classified with reference to psychoses, 1919

Psychoses	Total	Arizona	Colorado	Iowa	Maine	Massachusetts	Nebraska	New Hampshire	New York	Rhode Island	South Carolina	South Dakota
Traumatic	1								1			
Senile	79			6		26	6		30	2	9	
With cerebral arteriosclerosis	86			2	2	39	1	3	36	1	2	
General paralysis	226		2	4	6	102	1	1	103	4	2	1
With cerebral syphilis	18					13	1		3		1	
With Huntington's chorea	3								2		1	
With brain tumor	1					1						
With other brain or nervous diseases	11			1		8			2			
Alcoholic	170			3	3	96	2	5	57	4		
Due to drugs and other exogenous toxins	10			1		5			3	1		
With pellagra	3								2		1	
With other somatic diseases	33			2	1	14		3	12		1	
Manic-depressive	1,340	8	11	80	60	310	29	33	741	24	44	
Involution melancholia	114			12		36		3	61		1	1
Dementia praecox	1,375	4	5	60	20	553	26	17	561	35	88	6
Paranoia or paranoid conditions	71			4		37		2	28			
Epileptic psychoses	101		2	6	7	35	2	5	32	2	9	1
Psychoneuroses and neuroses	73				1	26	1	2	43			
With psychopathic personality	113			1	3	15	3		91			
With mental deficiency	126	2		6	5	41			59		13	
Undiagnosed psychoses	110			1	2	58			39	2	8	
Without psychosis	148	3			21	75*	1	7	12	2	27	
Total	4,212	17	20	189	131	1,490	73	81	1,918	77	207	9

* Includes 6 cases in which no diagnosis was made.

Table 9—Discharges of patients from state hospitals for mental diseases in eleven states, classified with reference to psychoses and condition on discharge, 1919

PSYCHOSES	TOTAL				ARIZONA			COLORADO			MAINE		
	Total	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise
Senile	215	10	109	96	......	5	......	......	......	......	......	......	2
With cerebral arteriosclerosis	194	19	95	80	......	......	......	1	......	......	......	3	1
General paralysis	328	1	151	176	......	3	1	......	4	2	......	2	4
Alcoholic	788	434	287	67	......	5	......	2	......	......	11	5	2
Manic-depressive	2,506	1,589	739	178	18	19	2	10	3	......	56	16	3
Involution melancholia	225	84	90	51	......	......	......	......	......	......	......	3	1
Dementia praecox	2,549	135	1,581	833	7	32	6	1	8	......	......	24	12
Paranoia or paranoid conditions	229	18	130	81	......	2	......	......	......	......	......	6	1
Epileptic psychoses	249	31	126	92	......	4	......	......	......	......	......	4	6
Psychoneuroses and neuroses	300	88	125	87	......		......	1	......	......	1	6	3
With psychopathic personality	235	123	94	18	.....	4	......	1	......	......	......	1	......
With mental deficiency	362	144	152	66	......	8	5	......	2	......	......	5	7
All other psychoses	956	397	295	264	13	15	1	2	......	......	9	6	3
Without psychosis	814	......	......	814	......	......	1	......	......	3	......	......	41
Total	9,950	3,073	3,974	2,903	38	97	16	18	17	5	77	81	86

Table 9—Discharges of patients from state hospitals for mental diseases in eleven states, classified with reference to psychoses and condition on discharge, 1919—Continued

PSYCHOSES	MASSACHUSETTS			NEBRASKA			NEW HAMPSHIRE			NEW YORK		
	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise
Senile		23	39		6	7		5	2	1	54	20
With cerebral arteriosclerosis	2	33	52		2	1		1	1	15	45	20
General paralysis		36	100		4	1		2			87	59
Alcoholic	173	128	56		3		3	9		183	121	8
Manic-depressive	164	162	103	16	36	1	21	21	4	837	348	55
Involution melancholia	15	18	30		2	1		5	3	64	58	14
Dementia praecox	22	409	480	1	39	1	1	12	10	63	754	236
Paranoia or paranoid conditions	1	30	49		5			3	2	10	71	17
Epileptic psychoses	7	26	47		5	4		6	1	18	46	10
Psychoneuroses and neuroses	12	36	62	2				5	3	57	65	16
With psychopathic personality		10	7	1	4					113	69	10
With mental deficiency	1	53	28		4	2			1	87	59	9
All other psychoses	52	95	215	4	8	1	4	4	2	152	117	29
Without psychosis			478†			3			29			52
Total	449	1,059	1,746	24	118	22	29	73	58	1,600	1,894	555

† Includes 37 cases in which no diagnosis was made.

Table 9—Discharges of patients from state hospitals for mental diseases in eleven states, classified with reference to psychoses and condition on discharge, 1919—Concluded

Psychoses	Rhode Island			South Carolina			South Dakota			Virginia		
	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise	Recovered	Improved	Otherwise
Senile	......	......	5	......	12	6	4	1	1	5	3	14
With cerebral arteriosclerosis	......	2	3	1	6	2	......	......	......	......	3	......
General paralysis	......	3	3	......	3	2	......	1	......	1	6	4
Alcoholic	33	11	......	3	2	1	1	......	......	25	3	......
Manic-depressive	37	9	2	117	......	......	10	2	2	303	123	6
Involution melancholia	......	......	......	......	1	1	2	3	......	3	......	1
Dementia praecox	......	35	24	......	146	26	4	7	11	36	115	27
Paranoia or paranoid conditions	......	1	......	1	4	1	1	......	......	5	8	11
Epileptic psychoses	......	4	6	3	16	11	......	3	2	3	12	5
Psychoneuroses and neuroses	1	5	......	2	5	3	5	1	......	7	2	......
With psychopathic personality	......	4	1	6	......	......	1	1	......	1	1	......
With mental deficiency	......	3	......	53	10	4	2	......	......	1	8	10
All other psychoses	10	11	4	29	14	6	17	4	1	105	21	2
Without psychosis	......	......	6	......	......	92	......	......	4	......	......	105
Total	81	88	54	215	219	155	47	23	21	495	305	185*

* Includes 8 transfers.

Table 10—Deaths of patients in state hospitals for mental diseases in twelve states, classified with reference to psychoses, 1919

PSYCHOSES	TOTAL			ARIZONA			COLORADO			IOWA		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Senile	739	823	1,562	15	1	16	33	21	54	70	42	112
With cerebral arteriosclerosis	462	309	771	......	......	......	9	4	13	5	3	8
General paralysis	1,126	301	1,427	16	4	20	39	9	48	60	8	68
Alcoholic	176	59	235	......	......	......	1	......	1	5	1	6
Manic-depressive	332	562	894	12	7	19	14	19	33	23	57	80
Involution melancholia	84	161	245	......	......	......	1	3	4	14	17	31
Dementia praecox	1,169	1,287	2,456	15	4	19	12	6	18	57	35	92
Paranoia or paranoid conditions	63	63	126	2	......	2	2	1	3	2	2	4
Epileptic psychoses	276	196	472	10	1	11	17	16	33	31	16	47
Psychoneuroses and neuroses	10	11	21	......	......	......	2	......	2	2	......	2
With psychopathic personality	18	19	37	4	1	5	......	......	......	1	......	1
With mental deficiency	139	140	279	3	......	3	......	1	1	10	6	16
All other psychoses	335	379	714	5	3	8	4	5	9	19	16	35
Without psychosis	51	29	80	......	......	......	10	3	13	......	......	......
Total	4,980	4,329	9,309	82	21	103	144	88	232	299	203	502

Table 10—Deaths of patients in state hospitals for mental diseases in twelve states, classified with reference to psychoses, 1919—Continued

PSYCHOSES	MAINE			MASSACHUSETTS			NEBRASKA			NEW HAMPSHIRE		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Senile	21	20	41	102	161	263	49	28	77	24	20	44
With cerebral arteriosclerosis	15	11	26	167	94	261	3	1	4	22	5	27
General paralysis	29	15	44	190	39	229	27	7	34	17	8	25
Alcoholic	2	......	2	67	23	90	2	......	2	7	1	8
Manic-depressive	19	16	35	36	65	101	26	27	53	1	13	14
Involution melancholia	......	4	4	13	28	41	2	3	5	2	3	5
Dementia praecox	19	13	32	280	277	557	8	21	29	22	16	38
Paranoia or paranoid conditions	2	1	3	6	6	12	4	......	4	1	......	1
Epileptic psychoses	13	4	17	28	20	48	13	6	19	9	4	13
Psychoneuroses and neuroses	......	......	......	......	4	4	2	1	3	......	......	......
With psychopathic personality	1	......	1	3	1	4	1	1	2	......	......	......
With mental deficiency	3	5	8	27	28	55	3	1	4	1	1	2
All other psychoses	11	12	23	89	84	173	12	4	16	4	10	14
Without psychosis	6	4	10	22	5	27	......	......	......	6	2	8
Total	141	105	246	1,030	835	1,865	152	100	252	116	83	199

Table 10—Deaths of patients in state hospitals for mental diseases in twelve states, classified with reference to psychoses, 1919—Concluded

PSYCHOSES	NEW YORK			RHODE ISLAND			SOUTH CAROLINA			SOUTH DAKOTA			VIRGINIA		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Senile	274	383	657	14	20	34	43	29	72	15	11	26	79	87	166
With cerebral arteriosclerosis	202	158	360	5	9	14	25	7	32	....	....	....	9	17	26
General paralysis	657	187	844	21	10	31	15	5	20	12	1	13	43	8	51
Alcoholic	80	32	112	6	2	8	....	....	....	....	....	....	6	....	6
Manic-depressive	107	232	339	4	12	16	11	9	20	2	2	4	77	103	180
Involution melancholia	49	100	149	....	....	....	....	....	....	1	2	3	2	1	3
Dementia praecox	629	771	1,400	31	27	58	18	25	43	20	15	35	58	77	135
Paranoia or paranoid conditions	33	42	75	....	1	1	....	....	....	....	....	....	11	10	21
Epileptic psychoses	114	80	194	5	7	12	10	7	17	1	....	1	25	25	50
Psychoneuroses and neuroses	3	6	9	....	....	....	....	....	....	....	....	....	1	....	1
With psychopathic personality	7	15	22	1	....	1	....	1	1	....	....	....	....	....	....
With mental deficiency	62	75	137	3	....	3	5	3	8	....	1	1	22	19	41
All other psychoses	123	168	291	5	8	13	22	27	49	7	2	9	34	40	74
Without psychosis	1	2	3	1	2	3	5	11	16	....	....	....	....	....	....
Total	2,341	2,251	4,592	96	98	194	154	124	278	58	34	92	367	387	754

ABSTRACTS

THE CARE AND TREATMENT OF THE INSANE IN MISSOURI. By S. W. Hamilton, M.D. *Monthly Bulletin*, Missouri State Board of Charities and Corrections, September, 1920. 172 p.

This is the report of an investigation recently conducted by Dr. Hamilton, of the National Committee for Mental Hygiene, in response to a request from Governor Frederick P. Gardner that the National Committee make a mental-hygiene survey of the state of Missouri. The care of the insane was taken up first and five months were spent in gathering the facts presented in Dr. Hamilton's report. [A separate survey of the care of the feebleminded in Missouri has since been made by Dr. Thomas H. Haines, Field Consultant of the National Committee for Mental Hygiene. See page 391.] Dr. Hamilton's report contains detailed information with regard to every public and private institution in the state in which the insane are to be found, including jails and almshouses. Dr. Hamilton was assisted by Dr. Clesson C. Atherton, of Peoria State Hospital, and Dr. Paul J. Ewerhardt, of Chicago State Hospital, and every effort to facilitate the work was made not only by Governor Gardner, but by the Organizing Committee of the Missouri Society for Mental Hygiene, the state board of health, the state board of charities and corrections, the staff of the state auditor, and many public-spirited citizens who were interested in improving conditions for the victims of mental disease.

Dr. Hamilton's main criticism of the situation in Missouri is directed against the policy that makes the county rather than the state responsible for the maintenance of the insane. Missouri is one of only six states that still throw the burden of supporting the insane upon the county. In 1918 the state contributed only 7 per cent of the cost of the maintenance of the insane, and its entire outlay for the insane and feebleminded together was less than 3 per cent of its expenditures. The most unfortunate result of such a policy, Dr. Hamilton says, is the detention of the insane in county almshouses. Among the more progressive counties this practice has already been discontinued, but as long as it is cheaper for a county to support its insane as paupers than to pay for their maintenance in a state hospital as patients there will be county officials willing to put the financial interest of the taxpayer above the welfare of the mentally sick. According to the findings of the survey, there are 285 mentally diseased persons now in almshouses in Missouri, some of them distressingly neglected and none of them receiving the care and treatment demanded by their condition. Complete state care of the insane in state institutions at state expense is the only practicable remedy for this situation.

Another reform strongly advocated by Dr. Hamilton is the abolition of the spoils system in the state hospitals for the insane, making tenure of office absolutely independent of political considerations. To illustrate the evils of the present plan, he cites the fact that since 1900 the four state hospitals have had twenty-eight superintendents, only four of whom served as long as five years. Such a system, he says, makes impossible a settled policy and a really progressive program.

He urges also the establishment of a state commission to have supervision of all the insane in the state, those in private as well as those in public institutions; a better organization of the state hospitals, giving the superintendents entire authority in the appointment and removal of their subordinates and making wages and salaries commensurate with the responsibilities carried; and better commitment laws, providing for voluntary admission to state hospitals, for emergency commitment, and for commitment for observation, and relieving the insane from appearance in court except by their own request.

THE TRAINING AND CARE OF FEEBLEMINDED PERSONS IN MISSOURI. By Thomas H. Haines, M.D. ***Monthly Bulletin***, State Board of Charities and Corrections, January, 1921. 26 p.

The survey, still uncompleted, of which this is the preliminary report, constitutes the second step in the mental-hygiene survey of Missouri undertaken by the National Committee for Mental Hygiene in 1919 at the request of Governor Gardner. The first step was the survey by Dr. Samuel W. Hamilton of conditions with regard to the insane. (See page 390.)

Estimates as to the number of feebleminded in Missouri based upon existing statistics vary widely. In 1916 Dr. J. E. W. Wallin, Director of the Psycho-educational Clinic of St. Louis, found 333 feebleminded children in a school population of 80,000—that is, about 4 to a thousand. The school population of Missouri in the year ending June, 1919, was 814,000. On the basis of Dr. Wallin's figures, this would give upwards of 3,600 feebleminded children in the school population. On this same basis, the number of feebleminded in the total population of the state in that year would be upwards of 13,000. On the basis of the army figures, which show a considerably higher quota of feebleminded for Missouri than for the country as a whole, these estimates would be increased about 75 per cent, giving more than 6,000 feebleminded of school age and more than 21,000 in the total population.

The actual figures obtained thus far in the mental-hygiene survey are as follows:

Dr. Hamilton, in his survey of the county almshouses of the state, found 443 congenital mental defectives—21.5 per cent of an aggregate population of 2,058. The extent to which propagation of the mental defectives in these almshouses is permitted may be judged from the fact that Dr. Hamilton mentions 19 instances of such propagation, though his report is concerned only incidentally with the feebleminded.

At the time of writing, Dr. Haines' survey included three orphanages in and around St. Louis; three state institutions for juvenile delinquents—the Missouri Reformatory, the Industrial Home for Girls at Chillicothe, and the Industrial Home for Negro Girls at Tipton; two city institutions for delinquents—Bellefontaine Farms, the St. Louis training school for boys, and the St. Louis Workhouse; the Missouri School for the Blind; and a number of public schools, both in small cities and in rural districts.

In the three orphanages, with a total population of 408, 16 feebleminded children were found and 22 border-line cases. Assuming that half of the 22 will eventually turn out to be feebleminded, Dr. Haines puts the number of feebleminded in these orphanages at 27—6.6 per cent of the total population. This is a small percentage compared with the figures obtained in orphanages in other states, but if even this percentage holds throughout Missouri's institutions for dependent children, there are more than 250 feebleminded among the upwards of 4,000 children in such institutions.

Of the 864 boys and girls in the state institutions for juvenile delinquents, 88 were found to be feebleminded and 74 of border-line intelligence. On the assumption that half of these latter will eventually prove feebleminded, it may be said that over 14 per cent of these juvenile delinquents are misplaced, since they are unable to profit by the discipline of a reformatory. This is true also of the defective delinquents in the city institutions. Among the 186 boys at the Farms, 10 were feebleminded and 21 of border-line intelligence, while there were 12 feebleminded persons and 8 border-line cases among the 145 inmates of the workhouse. These people will be no better fitted for life in the community at the end of their term than at the beginning; provision for their permanent custody is society's only defense against them.

Group intelligence tests at the Missouri School for the Blind in St. Louis have not yet been completed, but it seems probable that about 6 per cent of the children there are feebleminded. Not only is the costly education that they are receiving wasted upon them, but they are taking the places of children who would profit by that education.

In the public-school surveys, the best and the poorest school populations in each county were selected for study. Dr. Haines reports the results of two such surveys in central Missouri. In one county seven schools were visited. Of the 333 children in those schools, 23, or nearly 7 per cent, were classed as feebleminded. If this percentage holds throughout the entire school population (3,400) of this county, there are upwards of 200 feebleminded children in that school population. In the other county, situated in a better farming district, about 4 per cent of the children in the five schools visited were found to be feebleminded—5 in a total population of 126. These public-school surveys are being continued in other parts of the state.

The report closes with the following recommendations:

1. That the Missouri Colony for Feebleminded and Epileptics be enlarged to provide for 2,000 patients, with separate farm colonies for older boys and separate cottages for epileptics, idiots, and colored persons.

2. That a commitment law be enacted giving exclusive jurisdiction in cases of mental deficiency to circuit and juvenile courts and providing that discharge and parole shall be by the superintendent and board of managers or by the court committing, this provision to apply also to minors who are admitted by the superintendent upon the application of parents or guardians.

"3. That there be organized a traveling mental-hygiene clinic to be charged with making careful studies of children who are problems before courts or in schools, either by troublesome conduct and behavior or by failure to develop normally and progress properly in education. In order to be broadly useful, this clinic must be equipped to study the problems of childhood from every angle. This clinic must be able to bring to bear upon these case studies every kind of knowledge we possess concerning the development of mind and body. The clinic will study children who are nervous or neurotic, children who have pathological trends in the fields of emotion and volition, and children who are backward in the development of intelligence. It will use our knowledge of clinical psychology. It will have at its command psychiatrically trained social workers and it will be directed by a psychiatrist, either directly or through the state commission or bureau under which it is organized.

"4. That there shall be authorized and established some central agency for the supervision and direction, in the community, of such feebleminded persons, persons who, after school life, either do not need or cannot receive custody in a state institution. Such an agency will provide suitable employment and arrange proper home environments. It will visit such cases frequently and see that proper environing conditions prevail. It must be closely linked in its activities with the traveling clinic for schools and courts. Its work will be indicated by the facts ascertained by the clinic. It is literally to be the follow-up agent.

"5. That a state commissioner of mental hygiene, or a bureau of mental hygiene, shall be provided for and that this commission or bureau shall be given charge of:

(1) state institutions for the feebleminded,
(2) clinics for the study of aberrant children, and
(3) supervision and care of the feebleminded in the community after school life, to prevent their propagation and delinquencies.

"We recommend, on grounds of efficiency and economy, that the organization and direction of these lines of work for the training and care of the feebleminded shall be put under the same management as that recommended for the direction and control of the state hospitals for the insane, in the report on the *Care and Treatment of the Insane in Missouri*. One commissioner or one bureau of mental hygiene can effect economies in each field and can economize by combining the two interests in much of the clinical and after-care work recommended. The introduction of much needed efficiency in the work, both with the insane and with the feebleminded, depends upon the application of the principles of preventive medicine in the field of mental medicine. Both lines require a well-trained psychiatrist."

THE DRUG HABIT IN THE UNITED STATES. By Pearce Bailey, M.D. *The New Republic,* 26:67-9, March 16, 1921.

Wild rumors have been current during and since the war as to the extent of drug addiction in the United States as revealed by the mobilization. Dr. Bailey gives here the actual facts with regard to drug addiction in the army and the conclusions that can be drawn from them as to the number of addicts in the country.

It should be stated in the first place that the military authorities were actively opposed to the enlistment of drug addicts. Alcoholic inebriates they were often willing to accept, since the drinking man improves with abstinence. The drug addict, on the contrary, goes to pieces if he cannot get his drug. Consequently practically all cases of drug addiction that came to the attention of the authorities were rejected or discharged.

There were three points at which such cases could come to light—at the draft boards, at home camps, and in France. At the draft boards the total number of addicts discovered was 1,000 and at the camps and recruiting depots 2,120—3,120 in all among the approximately 3,500,000 men examined. Very few cases were reported in France.

The fact that all drafted men had to pass two sets of examinations and then to keep fit for six months before being sent over-seas makes it extremely improbable that many drug addicts escaped detection by the authorities. The addict cannot keep fit without a constant supply of his drug. While it is difficult to be positive in regard to such underground matters as drug traffic, Dr. Bailey is convinced that very little of such traffic was carried on in the home camps. Few instances of it came to light, though both the military and the civil police were on the alert for it. It is conceivable, however, that drugs were obtained by addicts in camps in this country. But it is inconceivable that such should have been the case in France, three thousand miles from the base of supply. Yet the hospital reports of the A. E. F. record only 70 cases of drug addiction admitted during the years 1917-19. The suggestion that large numbers of addicts may have "suffered it out"—that is, have endured the intense suffering that follows deprivation of the drug without seeking medical aid—is one that few who know drug addicts would accept. Self-cures of this kind are not unheard of, but they are very rare.

"What inferences can be drawn as to the number of drug addicts in the country from the 3,120 which represent the total culling of 3,500,000 men examined during the mobilization? Assuming that under stress the total of men falling within military age would have been 10,000,000, or three times the number of men actually examined, other things being equal, there would have been found 9,360 drug addicts. It is believed that that number would have represented more than the bulk of the male drug addicts in the country. Such a statement is vouched for by the age periods in which drug addiction occurs. It is an affair of youth—much more so than alcoholism is.

"According to the neuropsychiatric statistics of the army, 83.2 per cent were found between the ages of twenty and thirty, although Negroes averaged somewhat older. Addicts are younger than alcoholics, of whom the percentage falling in the same age period was 37.1 per cent. These figures as to youth bear out civil experience. Wherever drug addicts occur in large numbers, they collect in gangs. The members of these gangs know each other, congregate, and evolve a special vocabulary of their own. . . . Since the enactment of the anti-narcotic laws, gang formation has become particularly necessary to insure a constant supply of 'goods.' Now the members of these gangs are almost always young men. In the round-ups which take place from time to time, only here and there is observed any one more than thirty-five years of age. The majority of them are about the same age as those found in the army.

"In considering the total number of addicts in the country, women must be counted, but as to them no figures exist. The number of them is, however, in all probability far below the number of men, as women have little tendency to form gangs."

It is not Dr. Bailey's purpose to minimize the importance of drug addiction as a social problem, but he believes it to be a sectional rather than a national problem. The neuropsychiatric statistics, which recorded not only cases rejected at once, but also those who broke down after the supply of drug they brought with them to camp was exhausted, show that nearly one-half of all cases came from New York, California, Pennsylvania, Missouri, and Ohio. "More than one-fourth of all cases came from New York, more than from any other state, and consequently drug addiction is a more important problem in New York than anywhere else in the United States. The variations in the intensity of this nuisance in different parts of the country are due partly to conditions which make smuggling easy . . . and partly to the ingenuity displayed in different sections in evading the laws which are intended to limit the possession and sale of habit-forming drugs.

"One of the difficulties in the way of meeting the situation has been that drug addiction has too long been considered a medical problem. It is that secondarily only. On the theory of its being a medical problem and in order to minimize the suffering due to withdrawal, drug addicts have been 'registered,' and when registered have been allowed to receive opium derivatives in presumably decreasing doses. The doors were thus thrown open for addicts to supplement their supply and for persons who were not addicts to register, and thus to obtain morphine at reduced prices, which they afterwards sell.

"The problem is not one to be handled by the boards of health or by special commissions, but by the Internal Revenue Department, which should check up all sales by the municipal police and by the local and federal courts. It is difficult to believe that energetic measures could not stamp this evil out of New York."

BOOK REVIEWS

THE STORY OF A STYLE. By William Bayard Hale. New York: B. W. Huebsch, Inc., 1920. 303 p.

Psychoanalysis originated as a method of investigating the origin of psychoneurotic symptoms. It was soon found that these symptoms were related to the personal characteristics of the patients being treated, and much light was thrown on the psychology of dreams and other imaginative processes as well. A natural development of this was the application of psychoanalytic principles to the interpretation of artistic creations, particularly in literature. If the human psyche developed with as great a uniformity as does the body, the conclusions of such interpretations would be as valid and as accurate as we presume the paleontological reconstruction from fossil remains to be. Unfortunately the elements entering into the structure of the personality are so numerous and their relative importance so varied that it is impossible to reconstruct the character of an author with certitude from the study of those psychological fossils, his literary creations. Nevertheless, such studies are suggestive, and when taken into conjunction with other data, may justify conclusions of fair reliability. Without accessory data, however, the speculations are worth no more than a diagnosis based on a newspaper report of symptoms. They may be privately amusing, but from a scientific standpoint they are negligible or pernicious.

In this book the author attempts an analysis, not of the matter, but of the style in speaking and writing, of Woodrow Wilson. No professional psychoanalyst would be likely to call this "a psychoanalytic study," as does the publisher, but the method of approach has presumably been learned from such psychoanalytic literature as reaches the layman. The character of Mr. Wilson has been as great an enigma to those who know him personally as to the great mass of the public who have made his acquaintance only in the daily press. He is a man who has met with brief, but marvelous success, and in the midst of it has suddenly tumbled from his pedestal, not even sympathy for his illness preventing many people from scornful exultation over his collapse. What led to his eminence and what to his fall? Were the same characteristics responsible for both? Did he change or did public sentiment? Answers to these questions would teach us much about individual psychology and social phenomena. What does Mr. Hale offer us?

In his first chapter, *Prophetic Symptoms,* he analyzes the style of Wilson's early literary productions, beginning with an article published in 1879. He notes that one word in every three and three-fifths words is an adjective, while there are thirty adjectives to every pure verb. With the latter proportion, he compares that found in the writings of twenty-one recognized masters of prose. Not one of those used as many adjectives as verbs and the average proportion was thirteen pure verbs to four and a half adjectives. Verbs connote action, while adjectives qualify, limit, and often retard thought. In fact, "they eke out effortless poverty of ideas." He quotes a number of examples such as "thorough, exhaustive, and open discussion" to show that Mr. Wilson, even at this early period, was given to superlatives and unnecessary repetitions. In the phrase "nothing could be more obvious than"—used of a claim which might well be disputed—Hale sees evidence that young Wilson already had a conviction that his thoughts were axiomatically correct. A fondness for such frequently repeated introductory phrases the author would account for on one or more of the following grounds: "because his own cerebration is sluggish, or, though active, is repressed by internal conflict; or because he understands that allowance must be made for the incapacity of the people for following any rapid advance of thought; or because of more subtle recommendations, connected with the necessity which lies upon an oracle of leisure-class culture to put into evidence his familiarity with studied phrases, economically wasteful, and therefore distinguished, testifying to the fact that the author has spent years in ornamental, non-productive studies and has acquired the honorable habit of squandering his own time, and requiring that readers squander theirs, in the penning and the perusal of circumlocutions conceived as embroidering plain statements with the galloon of an antique grace." It must be admitted that this first chapter presents material that piques one's curiosity. Statistically, a tendency to circumlocution and unwarrantably strong statement seem to be demonstrated. That this may somehow be connected with basic factors in Mr. Wilson's psychology, one is not unprepared to believe.

A disappointment awaits one. Under the heading *Aristocratic Affectations,* Hale discusses the book on George Washington (1896) at length, and with brevity the baccalaureate address of 1908 entitled *The Free Life.* The former is characterized as "a romantic rhapsody about a handsome ghost." Innumerable quotations are offered to show a passion for pedantic terms, archaic expression, and elaboration of the aristocratic trimmings of Washington's life and society. Next he gives further evidence of addiction to adjectives. This addiction retards thought and is "the result of chronic constitutional doubt.'' The next object of attack is the frequency with which certain words are used, often with unusual meaning. Such favorites are *''counsel,'' ''process,'' ''quick,''* or *''touch.''* From all this Hale deduces that Mr. Wilson ''has deliberately modeled himself after what he conceives to be the character of Washington:'' the use of archaisms and redundant epithets is a pretense of aristocratic decoration. The discussion of *The Free Life* is confined to examples of repetition of favorite words.

In the next chapter on *Learned Addictions,* we meet with more quotations of the inevitable ''processes,'' ''counsel,'' ''quick,'' etc., more criticisms of set phrases and favorite needless introductions to sentences. These habits Hale regards as indicating a class ritual, an advertisement of membership in an academic guild superior to the common run of mankind and privileged to waste time with mere verbiage. This argument is enlarged in the succeeding chapter on *Symbolism.* In an admittedly sketchy way, Hale outlines the psychology of word symbolism, the transference of magic power to the spoken or written word. Ruling classes, he says, have always tended to use such magic to impress their inferiors. In Mr. Wilson's style he finds frequent examples of personification of inanimate objects—i. e., of animism. Mr. Wilson's apparent belief in the clarity and intelligibility of the text of the Versailles Treaty is held to be an example of word worship.

Under the caption *Phonetic Phenomena,* he claims to see evidence of lack of clarity in thought, native or the result of fatigue, in Mr. Wilson's style. Alliteration and repetition are held to be like the symptom of echolalia in the insane. The former is discovered in a fondness, which Hale ingeniously ferrets out, for the letters *p* and *s.* Many examples of repetition are cited. As to the use of repetition for purposes of emphasis and clarity, the author has nothing to say.

The next chapter, *Doubt and the Flight from the Fact,* is the most ''psychoanalytic'' in the book. The author begins by citing Mr. Wilson's fondness for rhetorical questions. He argues that this suggests a mock debate in which the speaker has an easy victory. But it is more than that. It may, says Hale, be a reflection of inner doubt, an alternation between a positive and a doubting attitude. ''Would it be strange if our studies led us to suspect Mr. Wilson's is really a character of peculiar instability of judgment and weakness of will?—that of a man torn by conflicting emotions, shaken by doubts of himself and his every thought and act, haunted by a never-to-be extinguished apprehension of his own inferiority?'' In a digression, doubt is held to be a result of conflict with reality, and over-positive statement a compensation for the inner doubt. This implies a hatred of facts. Although he does not say so, this is probably the reason for Hale's sudden insertion at this point of a small collection of picayune inaccuracies in fact and a longer list of what he alleges to be errors of expression. One of these is a facile grammatical error that may have been typographical; the rest are phrases or sentences that seem, torn from their contexts, to be inane. As a matter of fact, the strong arguments that Hale uses in this chapter are not drawn from a study of Mr. Wilson's public utterances, but are his notorious aloofness and a constitutional shyness that the President confessed to his critic personally.

In order to supply further evidence in support of his views, the author next presents *A Typical Manuscript*. "It is a typewritten 'manuscript' prepared for the President from memoranda furnished by him, the text conscientiously phrased in his own style by a student of it and revised by Mr. Wilson's own hand and pen." The alterations are supposed to be in the direction of the tendencies stigmatized by this critic. As a matter of fact, almost every emendation quoted seems, to the reviewer, to be in the direction of sense, of qualification or emphasis such as any author is entitled to make if the final product is to be accredited as his own. In this instance neither fatigue, faulty mentation, nor unconscious doubt can have produced these idiosyncrasies of expression, since they are all purposely added. It is, of course, possible that such factors might during the process of a lifetime lead to the development of a style that is in the end deliberately affected. If Hale means this, he should say so. His argument is, however, that Mr. Wilson is, at the time of utterance, sparring for time when he asks questions, piles up epithets, and so on.

So far the book deals only with defects. In the next chapter the author attempts to account for the popularity of this pseudo-historian and weak lawgiver. His very intellectual weakness may account for his success, says the critic. For instance, inner doubt has led to the development of an impressive pose of assurance; he "fulfils the popular idea of a philosopher who confers honor upon the sordid concerns of political life by bringing to them the high thoughts and ideals amidst which he lived so long in cloistered contemplation above that which the vulgar are permitted or are fit to enjoy;" as to the spell of his language, "Vagueness and reiteration, symbolism and incantation, I take to be the chief secrets of Mr. Wilson's verbal power," devices that have peculiar influence over crowds.

The last chapter is devoted to excerpts from the League of Nations speeches made in the autumn of 1919. In these there is nothing new. It is essentially an appendix in which the author gloats over a high percentage of the stylistic defects previously exposed and pitilessly illuminated.

So much for the material. What is its value? The first point to be noted is that his analysis is convincing only when his conclusions coincide with opinions now widely held about the peculiarities of Mr. Wilson. It is comfortable to be given a "scientific" proof justifying a suspicion or prejudice, so many readers will probably exult in these pages. Had Hale attempted to show that the President has unconsciously modeled his life after that of, let us say, Napoleon—a not unthinkable hypothesis for idle speculation—the reader might yawn rather than chuckle. As a matter of fact, one can neither prove nor disprove such claims as are made in this book. The underlying factors here exposed are not unique; few people are without such tendencies. Their importance lies in their relative strength or weakness. Hale, of course, tries to show that they are dominant, but he cannot do this accurately without evaluating such counter tendencies as may exist in Mr. Wilson's character. If one were to compile a list of the exaggerated, truculent statements of Theodore Roosevelt, leaving out of consideration his other traits, he could be demonstrated as a ravening monster. But such a work would not be popular.

But let us assume that Hale has painted a fair portrait. The psychological features now exposed would certainly account for Wilson's failures and many of his peculiarities. But why did collapse come when it did? Did these characteristics become accentuated or did human gullibility suddenly cease? Hale offers us no evidence of such changes. More important than this, he gives us no adequate reason for Wilson's rise to power. It is true that he offers an explanation for domination of a mob, but the President, during his career, has reduced to an almost servile devotion to his policies university professors, hard-headed men of business, and the astutest of politicians in this and other countries. The spellbinder whom Hale depicts would make a successful vendor of patent medicines at a country fair—no more. Mental inferiority and unconscious cowardice may account for temporary lapses or peculiarities, but Wilson's eminence can have been achieved only in spite of these hypothetical defects and in virtue of other character traits of which Mr. Hale is ignorant or secretive.

At best, then, this analysis throws some side lights on the character of a public official while it pretends to explain his whole personality. What is its *raison d'etre?* A zeal for dispassionate scientific inquiry can hardly have prompted it, as the product is neither dispassionate nor scientific. In his foreword, the author explains that it was originally a chapter for a book on a related subject which he read to some friends. They advised him to elaborate it into a book. Such long-distance "psychoanalyses" as this may be all right as liqueurs sipped around the fire by congenial guests after a heavy intellectual repast, but when they appear in book form, one is forced to look for a hidden motive. One possibility is that the author hopes to make money by pandering to the popular taste for torture of fallen heroes. There is no discernible evidence for or against this view. A more probable hypothesis is that he is paying off some private grudge or blowing off some highly compressed personal steam; in other words, that the critic's own complexes provide the motive.

There is an adage, "Get thief to catch thief." Let us for a moment apply Mr. Hale's methods to the examination of his own style. Every page is littered with adjectives and epithets; how about the proportion of words of action to those of qualification in the following? "This is precisely what the discriminating brain, the informed intelligence, the sensitive ear, and the educated pen, are for. [He criticizes Wilson for ending a sentence with a preposition.] The point is that the promiscuous, indolent, incorrect, inaccurate, and tiresome recourse to a few pompous words borrowed from half-forgotten scholasticism neither represents nor allows clear, differentiated, exact, and thorough thinking." (p. 97.) In place of saying "appropriate," he says "germane, genuine, appropriate, and accurate." (p. 83.) These quotations are typical. He speaks frequently of his book being "swiftly moving," yet it is padded to the point of flatulence. He makes this remark once after seven pages of pure irrelevance, a coincidence not meaningless to a psychoanalyst. Repetition in the President's writings calls for frequent comment, yet Hale not only repeats evidence, but confuses his discourse by recapitulating various claims at inappropriate stages of the argument. A man who writes, "every minute of sixty seconds," cannot be in a great hurry. He does not repeat words as Mr. Wilson does when he wishes to convey a second or third time precisely the same idea. He has apparently a phobia of this, and so gives either a word of a slightly different meaning or piles up synonyms. The following sentence is interesting from this standpoint: "For ordinary purposes ordinary facts appeal to our attention in one or another of their more obvious, more homely, more prosaic attributes." One would suspect that the author, consciously or unconsciously, started "ordinary" a third time and was held up by lack of the courage Mr. Wilson displays. This phobia of repetition leads him to write "vocable" or "locution" for "word" and "locutory contribution" for "phrase." He has no favorite refrains of special phrases, but he has a penchant for certain words such as "meticulous," "echolalia," or "cerebrate." The latter is sometimes forced to strange uses, as when he writes, "Books are not written to insist upon, or cerebrate, attributes so familiar."

As to Hale's idolatry of words there is much evidence. He talks of the "nobility" of the word "process" and seems to have a horror of Wilson's sacrilege in using it in many senses. Archaisms are not infrequent. There is "writ" for "written," "eke" for "also," and so on. The sentence, "These all be excellent words," is not unique. The text is riddled with pedantic or unusual words and phrases such as: reluct, paludamentum, mattoid, hieratic, obnubilation, heliotropism towards certain sounds, lusory, predaceous, acousmatic improvisation, subnormal intellectuation, unweeting, understanded (for understood), antanaclasis, increditable. Such words can hardly be used solely to express the simple ideas of the author; a desire to impress the unlearned reader probably lurks behind. Alliteration is frequent; in fact, the title of the book is alliterative and thereby inaccurate. "Analysis," rather than "story," "of a style" would suit the meaning better. The mania for collecting interminable lists of words and phrases is probably connected with this word complex.

The author deplores Mr. Wilson's tendency to superlative statement and final pronouncement on matters that of their very nature must be only opinions. Yet he is not above writing "most obvious" himself. In criticizing Wilson's phrase "calamitous shipwreck" as containing an unnecessary adjective, *his* sentence contains "complete catastrophe." On page 51, Hale works himself up beautifully to a positive statement such as he deplores. He is writing of the inevitable epithet. " . . . does it not seem as if an author must lack confidence in the ability of the unassisted name of a fact to convey the fact? May we not be getting in this addiction, the extent and obstinancy of which we now begin to see, a symptom of *habitual misgiving?* Whatever else there may be to it, *the suspicion cannot be escaped that this is no mere verbal embroidery, but* the result of chronic, constitutional Doubt." Can one look for a more *ex cathedra* pronouncement than the following? "I speak with the full wisdom of all science when I assert that the attention of the hearer or the reader needs stimulation two or three times every minute of sixty seconds."

The defects of style common to these two writers must naturally lead to lack of clearness at times. Hale says—and takes a paragraph to say it—that the sentence, "This nomination comes to me quick with a sense of obligation," has no meaning. To the reviewer it seems translucent, if not transparent. But when he reads a few pages further on, "The sentence-preface, like all affectations of polite letters, belongs in the category of conspicuous consumption, and is of quite special honorific value in the scheme of predatory life"—at this point he finds Mr. Hale's style opaque.

Many readers and auditors have thought that the President enjoyed facility and charm of expression. It may be that his critic enjoys facility, and lacks charm, of expression. He is not dignified, but "smarty." He calls "counsel" and "process" Mr. Wilson's "Gold Dust Twins." Speaking of Jesus, he writes, "His own sayings are not as popular as those of his chief publicity agent, Paul of Tarsus." The imaginary creature whom Mr. Hale criticizes could have written the following "journalese," but not Mr. Wilson: "But never, until September 23, 1920, surely, here, or anywhere since Music, heavenly maid, was young, have the echoes of symbolic sound thus, in the spent retirement of articulated reason, chanted the magic cadence of reverberant phrase:" (p. 297.) Can one conceive of an author interested only in scientific argument descending to such a despicably cheap ruse as that found on page 14? He there writes, " . . . it is *sincerely* hoped, in the interest of the unprejudiced unfolding of the argument, that the conscientious reader will not at this juncture turn to page 160 and read the quotation there." The italics are mine.

Hale has much to say about Mr. Wilson's "aristocratic affectations." He is not without snobbishness himself. He lets the reader know from time to time that he has enjoyed intimacy with two presidents. He hurls his learning at the multitude and suddenly becomes democratic. He unbends. He tells the humble reader how he was looking for a book to finish a cigar with and took down Le Bon; how his maid has just brought him his mail with another Wilsonian document; how his little boy is interested in the manuscript and offers an analogy from Mark Twain. Could a man to whom literary—or other—dignity was natural be guilty of such irrelevance?

This is enough to demonstrate two things—that the author suffers from the same "complexes" as the subject of his criticism and that he cannot get away with them. If one assumes that he is jealous for this reason or that he is a disaffected disciple, the motive in writing the book becomes clear. He wrote a biography of the President some years ago, quotations from which do not seem to be disparaging. Does he regret it now? One wonders whether he is the conscientious student of the President's style who wrote the manuscript corrected by Mr. Wilson and now in the hands of the critic. If hatred be responsible for the book, there is surely evidence of it. Innuendoes and frank insults are found in every chapter. He implies that the President is a "mattoid," a schizophrenic, a coward, and states, "It is impossible to ignore the fact that his writings are marked conspicuously and obstinately by some of the signs often associated with subnormal intellectuation."

The reviewer comes neither to bury Cæsar nor to praise him. With the question as to whether these "complexes" exist in Mr. Wilson's psychology, we can offer no further opinion than that given above—

namely, that their existence is not of so much moment as their relative strength. But what we have a definite opinion about is the prostitution of a method of scientific research for the ventilation of a private grievance. This is a definite perversion of the principles and practice of psychoanalysis. Mr. Hale does not seem to know or prefers to hide the knowledge that *unconscious* tendencies may enter into character formation, but that the personality of the subject is an entirely different affair from his unconscious. The layman cannot see this discrimination and hence an unconscious wish means to him a character trait. These psychoanalytic "complexes" become admirable weapons for the assassin. If captured, he says he did not mean to stab and points to the *un* in unconscious; but he knows and counts on the actual effect of his words. It is not considered good taste by some folk to hit a man when he is down, but it is apparently all right to butcher him for an academic holiday. Mr. Hale would presumably reply that such analytic studies may teach people wisdom in the choice of leaders. We wonder if he would have had the courage to print this book in the summer of 1917.

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Lectures on Modern Idealism. By Josiah Royce, Ph.D. New Haven: Yale University Press, 1919. 266 p.

It is a bit surprising to find that there are changing fashions in philosophy as in drinks. A generation ago, philosophic idealism, cut after the Kantian pattern, was the approved dress for one's sober thoughts about reality. Then James, Schiller, Dewey, and others introduced a new style called Pragmatism. There was also New Realism. So that only yesterday it seemed that idealistic philosophy had gone the way of cocktails, highballs, and the rest. When, recently, May Sinclair published her *Defense of Idealism,* she admitted that idealism was out of date. "There is a certain embarrassment," she said, "in coming forward with an Apology for Idealistic Monism at the present moment. You cannot be quite sure whether you are putting in an appearance too late or much too early." She went on to add that some day—which may be as distant as you please—the reigning philosophies would grow old and die and a new idealism would be born again.

The thing has happened. There can be no doubt that the last few years have seen a revival of the philosophy of the Absolute.

It is fitting, as it is impressive, that the foremost American representative of this philosophy, although dead, should be heard anew at this time. I have in mind the two posthumous volumes by Josiah

Royce just published—*Fugitive Essays* and *Lectures on Modern Idealism.* This review deals with the latter of the two, issued under the competent editorship of Dr. J. Loewenberg.

"We have particular reason," as Dr. Loewenberg says, "to value at this moment a dispassionate estimate of that phase of philosophy which, like German music, must suffer through the retrospective judgment of the war. . . . An unbiased and trustworthy study of German idealism is, therefore, a most notable bequest to the present bewildered generation." There is, however, little reason to hope that the book will accomplish much in this direction. Most men who concern themselves with the matter at all find it difficult, as the editor himself does, "to condemn the German war lords and admire her philosophy" because "the boundary between her war and her philosophy is not easy to define." The reason is that most men interpret the war in the same simple terms as the editor does; it appears to them a "treacherous onslaught upon the peace of the world" by a people philosophically misled to do the wicked deed.

The point is important because it brings us face to face with one of the central inconsistencies of absolute idealism, a point which Dr. Loewenberg fails to consider, but which needs to be made clear, else the philosophy in question receives credit beyond its deserts. Dr. Loewenberg defends German idealism against its misinterpretation by the Germans. He is deeply impressed by Royce's righteous indignation at the behavior during the war of the people who had philosophic idealism to fall back upon. One gets no hint of the count made against this idealism again and again—namely, that, in consistency, human ills and wrongs should from the absolute point of view be a matter of indifference. The last notable act of Royce's life was a ringing public denunciation of the sinking of the *Lusitania.* The denunciation was prompted by the noblest emotions. Friends and former students dear to him went down in the *Lusitania,* and his heart spoke out. And yet, even while one honors him for his humanity, one may find his denunciation logically inexplicable, since it is uttered by a philosopher for whom evil is a divine necessity, who taught that evil had to be in order that evil might be overcome by good.

The subject has been brilliantly discussed by Santayana in his *Character and Opinion in the United States.* "Orthodox Hegelians," he writes, "might well have urged that here, if anywhere, was a plain case of the providential function of what, from a finite, merely moral point of view, was an evil in order to make a higher good possible—the virtue of German self-assertion and of American self-assertion in antithesis to it, synthesized in the concrete good of war and victory, or in the perhaps more blessed good of defeat. What could be more unphilosophical and *gedankenlos* than the intrusion of mere morality into the higher idea of world development? Was not the Universal Spirit compelled to bifurcate into just such Germans and just such Americans, in order to attain self-consciousness by hating, fighting against, and vanquishing itself? . . . Of course; and yet somehow, on this occasion, Royce passed over these profound considerations, which lifelong habit must have brought to his lips. . . . The murder of those thousand passengers was not a providential act, requisite to spread abroad a vitalizing war; it was a crime to execrate altogether. It would have been better for Hegel, or whoever was responsible for it, if a millstone had been hanged around his neck and he, and not those little ones, had been drowned at the bottom of the sea."

Certain minds, however, find nothing objectionable in idealism's position on the subject of evil or in its degradation of the world and its business to appearance and illusion. Unlike William James, who advised us that we go round it as round a marsh lying in the way of progress, they are temperamentally predisposed to accept a philosophy in which all differences are swallowed up in one eternal unity and all finite values in one eternal good. Such souls can go to no better source of refreshing than post-Kantian idealism, the greatest representatives of which—Kant, Schelling, and Hegel—are discussed in this book.

Kant, Schelling, and Hegel, although not equally, are all notoriously hard understanding. In the case of Hegel, there is the additional obstacle of inadequate translation of his works. It is difficult to imagine how the inner meaning of these philosophies could be more clearly and understandingly presented than by Royce in this little volume. The chapters on Hegel especially are to be highly recommended to those who desire an authoritative, fundamental, yet comprehensible statement of the heart of this dark philosophy. Of the ten chapters, two are devoted to Kant's view of knowledge and the self, in which Royce shows how the later idealisms were the inevitable development of Kant's position. Three chapters treat of Schelling and the strivings of his period. Here Royce makes clear how Kant's conception of the self expanded into the absolute and discusses the social implications of the self as thus conceived. Four chapters on Hegel follow, the study being based on the *Phenomonology* rather than on the *Logic*. A final chapter deals with *Later Problems of Idealism and its Present Situation*. In this chapter Royce considers and evaluates various reactions to idealism and finds them all wanting. The reason is that all of us are idealists, whether we will it or no—even without knowing it. If one objects to a given type of philosophy or conception of reality—say to idealism—one does so on the basis of some criterion, some ideal of what philosophy or reality must be; ergo, one is an idealist. Thought, through the use of an ideal, implies an idealistic philosophy. For "so to act is essentially, whether we know it or not, to view the temporal as the symbol and the likeness of the eternal." "This is why the idealistic movement . . . although frequently suppressed, although often deliberately ignored, has been as constant as the movement of a great river beneath masses of winter ice. Every now and then the ice breaks or melts, and the idealistic tendency comes to the light of consciousness. It is irrepressible, because it is human."

The book ends on this note of challenge. Whether one agrees or not, the volume revives one's sense of loss in the death of America's foremost spokesman for God as the absolute experiencer.

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STUDIES IN CONTEMPORARY METAPHYSICS. By R. F. Alfred Hoernlé. New York: Harcourt, Brace, and Howe, 1920. 314 p.

Another recent addition to the literature of philosophical idealism in America is *Studies in Contemporary Metaphysics*, by R. F. Alfred Hoernlé, formerly at Harvard. The book discusses some of the most interesting contemporary problems of a more fundamental kind, such as the nature and function of philosophy, mechanism and vitalism, theories of mind, the credentials of scientific method, the validity of religious insight, and so on. The studies are conceived in the spirit of Bernard Bosanquet, to whom the author feels himself indebted for the essential framework of his thinking, and they are distinctly the confession of philosophical faith of a man who desires above all to breathe the atmosphere of "that realm of speculation where great thoughts do not age."

The chapters of most interest to the non-professional reader will be the first and the last: *The Philosopher's Quest* and *Religion and the Philosophy of Religion*. Through these, moreover, he will gain an insight into the circle of ideas and the methodology of the outstanding form of present-day idealism. He will also become acquainted with the logic peculiar to this type of thinker, a logic that has a certain kinship with magic. Whether he finds this quality obnoxious or the reverse will depend very largely upon whether he is himself of the idealistic persuasion.

There is no doubt that a genuine nervousness has overtaken the philosophers of the present. In view of the world-wide agitations of the hour, and the enormous accumulations of knowledge, they have been forced to reëxamine themselves and their function in the world.

In a very readable and suggestive chapter, Mr. Hoernlé discusses the question, what is philosophy? "Once again," he says, "this has become a burning question for philosophers." Science, religion, men in the street have joined in an attack upon the claim of philosophy "to offer a profounder and more comprehensive insight into the nature of the universe than any other mode of thought." It is this question that the author proposes to answer.

Philosophy, we are told, aims at wholeness. This is its differentia. But the wholeness can no longer be a quantitative wholeness. A total-view of the universe in all its detail of fact is out of the question. The wholeness must be qualitative instead of quantitative. And this turns out to be, as Mr. Hoernlé goes on, the organization or interrelation of facts, rather than an encyclopedic knowledge of facts as such. In everyday life facts do not come to us as insulated bits, but as connected, as mutually illuminating elements in a larger setting. One thing throws light upon another; we understand one thing by virtue of its relation to another. "The spirit of philosophy, then, as exhibited in philosophizing, is the highest form of the principle of wholeness which is present throughout the life of mind wherever something is being learned in, and from, experience." However, since the organization of facts implies a knowledge of the facts, it would seem that the completest form of organization would imply the completest knowledge of facts. In other words, we may ask the author whether a qualitative wholeness of facts is thinkable without a quantitative wholeness? Mr. Hoernlé has this difficulty in mind, and his answer, though given in somewhat new terminology, is not new in content or meaning. "The data and materials for philosophical reflection," he tells us, "are not the crude and chaotic experiences of immature minds, but the already highly organized systems of experience in which mature minds participate through their feelings, thoughts, and actions."

As he develops the idea, we discover that the philosopher takes as his starting point such organization as has already been arrived at in the arts, science, religion, economics, politics, etc., and extracting "the essence, or real nature of each type of experience," penetrates to the deeper meanings of things by the arriving at a wholeness of these partial wholenesses. To put it in less elegant language, the philosopher takes the gist of the various knowledges, kneads them thoroughly, and then bakes a philosophical biscuit.

The fallacy here is, I was about to say, obvious, but it is possible that idealism is one of those cults that can be understood only after one has surrendered to them. At all events, it seems to me rash to conclude that one can take over into one's mind the essence or central meaning of a science, an art, a discipline of any sort without going through the vigils and toils necessary to achieve that central meaning—if, indeed, there be such. If certain philosophers will persist that the job of philosophy is to build a universe out of the multiplicity of facts accumulated and organized by other investigators, it seems to me they are not justified in putting the really arduous labor on the shoulders of some one else. Not because it is not nice to do so, but because insight into the central meaning of the specialized fields of investigation cannot be sipped up. To get at the heart of a science, we must live with that science, and so of an art.

Mr. Hoernlé makes this very point—and in an exaggerated form—when discussing religion. There he goes so far as to claim that "the student of religion, if he is not to miss the heart of the subject, must himself be religious." He must know what it is to be religious by being it—else "we may bluntly say that the student will not know what he is talking about." Accepting this criterion for the sake of argument, we may bluntly say that only a man at home in a specialized field of knowledge is really acquainted with its "central truths." Only a composite genius—physicist, chemist, biologist, mathematician, and all the rest would be qualified to do what Mr. Hoernlé demands of the philosopher.

The situation is actually worse. For what Mr. Hoernlé means by religion is not what is generally meant; it has nothing to do with the creeds or organizations we know. The religious person is the philosopher—as the self-conscious organizer of knowledge *par excellence.* In other words, what his claim comes to is this: no one not a philosopher can say anything ultimate about philosophy, but a philosopher is in a position to talk profoundly about anything. He has the key. I do not mean for a moment that this is Mr. Hoernlé's spirit, but only that the logic of his position forces me to that conclusion.

Here, then, we have the theme of the book, and its pages are devoted to the discussion of views which agree or disagree with it. There is a certain wonderful unity underlying our chaotic experiences; the sciences, the arts, religions in the ordinary sense attain to certain aspects of this unity, and the philosopher penetrates to those deeper unities, achieves that profounder organization which accounts for the unities met with at more superficial levels. In this search and the contemplation of the unity thus attained he finds the life most worth while.

M. C. Otto.

University of Wisconsin.

THE SOCIAL DISEASES: TUBERCULOSIS, SYPHILIS, ALCOHOLISM, STERILITY. By J. Héricourt, M.D. Translated, and with a final chapter, by Bernard Miall. New York: E. P. Dutton and Company, 1920. 246 p.

The question of depopulation in France has been the subject of much agitation for a number of years. In the last year or two, however, the problem has become much more acute, and it has now come about that the death rate is in excess of the birth rate. This is, of course, a matter of great concern to the French nation, with the ever-present fear of German aggression. Dr. Héricourt's point of view is unquestionably contingent on this fear of the depopulation of France. It is a matter which touches every patriotic Frenchman. Dr. Héricourt in his book has taken up this French problem from the standpoint of the physician writing as a sociologist. It is the major diseases of society, as he sees them, that he discusses. To quote from his preface, "the diseases which come under this heading are four in number. (They are tuberculosis, syphilis, alcoholism, and sterility.) Tuberculosis and syphilis are diseases of parasitic origin. . . . Alcohol is a toxic malady—a disease of *intoxication,* using the word in its medical sense; a poisoning of the organism. Sterility is a functional disorder or disturbance; it may be deliberately induced. Such are the four great scourges from which all modern societies are suffering, but which threaten more particularly the oldest civilizations. They are more terrible than even the most terrible of wars; for wars, even the most destructive, are passing accidents from which societies recover fairly rapidly, as individuals recover from a serious loss of blood, while their very lives appear to be seriously threatened by the advance of any one of the four plagues which have stricken them."

The author attempts to consider these four plagues from the standpoint of medicine and of sociology. One has to agree with this socialized point of view concerning the treatment of these conditions. For instance, in the consideration of tuberculosis, he condemns the usual method of treatment, which does little good to the patient and leaves him as a source of contagion to the community. He advocates isolation of the contagious cases in proper hospitals, with subsidies to the families who are deprived of their breadwinner because of hospitalization. Irrespective of the cost, which he admits would be very great indeed, he believes that this would be a great economy to the nation in the end.

Again, his views concerning the campaign against syphilis are to be commended. He strongly criticizes the French method of examination and licensing. His criticism of the French attitude toward restriction of birth and abortion is evidently well taken, and every one would probably agree with what he says concerning the damage done to individuals and the nation by the large imbibition of alcoholic beverages.

In so far one may agree with the author, but for the rest the American reader will probably disagree heartily. There is much in the book that has the tinge of ardent propaganda rather than the portrayal of facts. For instance, the author looks upon hereditary syphilis as the basis of tuberculosis. Again to quote the author, "nine times out of ten I have discovered the stigmata of heredito-syphilis in patients suffering from a confirmed tuberculosis. . . . There is almost always a parallelism between the severity of heredito-syphilis and the gravity of tuberculosis. . . . The terrible increase of tuberculosis . . . can only be the consequence of a similar increase of syphilis." He further indicates that almost every disease is the result of hereditary syphilis, and he even goes so far as to include appendicitis and the bearing of twins as evidence of syphilis in the ascendants.

From reading Dr. Héricourt's work, one would judge that whatever disease or difficulty is not due to syphilis must be due to alcoholism in the parents, as he feels that nearly all Frenchmen are afflicted with alcoholism and at least one-third with syphilis. It is easy for him to draw the conclusion that everything occurring in the way of disease, crime, or difficulties must be due to one of these two causes.

His outlook for the future in regard to alcoholism in France is entirely black. He has no confidence that the government or the French people will do anything to remedy their excessive alcoholism.

As to the part of his book concerned with the question of sterility, we fear that he will give much offense to the feminine readers of America. He states that the most obvious influence in causing a reduction of the birth rate are the modern feminist ideas which take the woman out of the home and lead her to compete with man in all departments of his activity. "Woman, wishing to assimilate herself to man, has realized that she will succeed in so doing in proportion as she suppresses maternity, which for the adepts of femininism has become a blemish."

As is apparent in reading this review, the book offers considerable material for criticism. The chief defect it seems to us is that Dr. Héricourt has not always stuck strictly to a scientific criticism of his statements. This makes the book valueless or worse to the casual reader, who is not familiar with the facts and figures of present-day knowledge concerning tuberculosis, syphilis, and alcoholism. If one can read the book without regard to its inaccuracies, it will be found to contain a number of interesting ideas, and the author is certainly to be commended for his socialized attitude towards the handling of diseases and conditions which so greatly affect the health, life, and future of France. The reviewer would advise against the reading of this book by the layman. It would be too likely to lead the uninitiated to accept as facts the wildest hypotheses of Dr. Héricourt and lead to an unscientific and perverted view of the subject matter under consideration.

H. C. SOLOMON.

Boston Psychopathic Hospital.

A TEXTBOOK OF SEX EDUCATION. By Walter M. Gallichan. Boston: Small, Maynard, and Company, 1921. 294 p.

Mr. Gallichan is the author of two other books, *The Psychology of Marriage* and *The Great Unmarried.* I have not read either, I am sorry to say, but shall do so, having read this *Textbook of Sex Education.* The latter is a scientific treatise of sex education, designed especially for parents and teachers, which will undoubtedly be of great help to those who appreciate the importance of proper physical and mental sex development, but who have not the knowledge of the subject ordinarily gained through extensive reading of scientific literature and work with case material. I believe that Mr. Gallichan has presented the subject with great care and yet as completely as is possible in a book of this size. There has been much repetition, but that is excusable in his argument for the right of children and young people of both sexes to acquire gradually a comprehensive knowledge of sex (for we know how much repetition is necessary to make the public comprehend clearly). His book is eminently free from faulty statements, is well systematized, and contains much well-gradated didactic instruction, of value to parents and teachers who do not know how much to tell children about sex, or how to formulate this information. He does not neglect biological, physiological, or psychological factors.

He scores the parents of fifty years ago—and since that time—who "counseled chastity and left the rest to 'natural instinct' " and states that he has endeavored in his book "to systematize a method of teaching which will be helpful to parents and to all who have the care of children and adolescents. . . . This is not a book for the young, but for the instructor. It has been arranged to supply a basis of sex education, and the *Lessons* given may suggest many others. The discretion of the parent must always be exercised in accord with the child's sex, age, and temperament."

"Anthropology and psychology, and more especially the investigation of the subconscious, or unconscious, self, are demonstrating that the fear of sex has never been absent from the minds of men. The association of sex with the holy, or the forbidden, and the widespread ascription of danger in the union of the sexes, cannot be banished from the human brain in a few generations. Yet slowly we are approaching, for the first time in man's history, a sane intellectual perception of the sexual impulse. The more widely the subject is studied, the stronger becomes the conviction that an eternal ignorance has misled humanity."

"Undoubtedly the character and the manner of sex education are of supremely vital importance; but the enlightenment must certainly be as sound in the case of girls as in boys."

"The sexual problem exists for all of us, and although civilization intensifies the problem, it provides also, by the extension of knowledge, science, and experience, the means for grappling with the difficulty."

He appreciates that there must be great difficulty in finding well-qualified monitors. "It is therefore necessary that parental and scholastic enthusiasm must be fostered by every possible means."

"The new psychology of the child shows, without doubt, that the withholding of the truth injures the emotional and intellectual relationship between parents and their children. One well-meaning lie repeated by the father or mother may destroy forever the confidence of the child. A severe reproof in response to a childish question or speculation upon reproductive enigmas acts as an excitant to further curiosity and speculation. Parents are wont to imagine that the hushed voice or the admonition to silence checks the inquisitive tendency. No doubt such tactics check the child from further attempts to learn from the parent or teacher. But instead of diminishing the curiosity, the evasive answer or the palpable untruth stimulates a deeper craving for enlightenment. This is an inevitable consequence."

"The education of parents must be undertaken in very many instances before we can begin to educate the children."

He suggests that "as a preliminary it would be well if the instructor placed himself in the hands of an expert psychoanalyst." "Psychoanalysis explains the origin and the meaning of the inner censor who whispers that we had better avoid this or that inquiry." "The new researches in psychology have let in a stream of light upon the mysteries of mental disease, the bewildering problems of sex, the significance of myth and legend, the association of art and life, the subject of education, the development of the mind of the child, and the social customs of mankind." "The new investigations into the subconscious mind, the origin of the perplexities and dreads, and their reaction upon thought and conduct are clearing away a cloud of primitive misconceptions and hindering delusions." "If the prospective teacher cannot purge himself from hindering reactions and realize that this is one of the most urgent of all reforms in education, he is certainly unfitted for a solemn task. . . . We must avoid the dry-bone method of instruction as cautiously as we steer clear of undue emotionality. Our teaching should be soundly scientific, with an admixture of æsthetics and poetry. The moral aspect of the subject must not become a dreary exhortation, but hopeful, practically helpful, and inspiring."

Mr. Gallichan's book is gratifyingly superior to the majority of similar published contributions, so many of which are disappointing through erroneous statements and through vagueness and lack of systematization. It is especially noteworthy that the author has the courage to give examples of instruction for didactic use.

GLENN E. MYERS.

Los Angeles, California.

THE OPIUM MONOPOLY. By Ellen N. LaMotte. New York: The Macmillan Company, 1920. 84 p.

This little book gives authentic information concerning the manufacture and distribution of opium. The author utilizes official "Blue Books" and demonstrates that a considerable proportion of the world's opium supply is obtained from India, Turkey, and Persia. She gives prominence to the following passages from the *Stateman's Year Book* for 1918: "Opium: In British territory the cultivation of the poppy for the production of opium is practically confined to the United Provinces, and the manufacture of opium from this region is a state monopoly. The bulk of the exported opium is at present either sent to the United Kingdom or supplied direct to the governments of consuming countries in the Far East; a certain quantity is also sold by auction in Calcutta at monthly sales."

One of the chief arguments of the writer is to the effect that the opium sold by monthly auction in Calcutta finds its way through unlawful channels to China, to the United States, and to other countries. The author directs our attention again and again to the fact that Great Britain is the chief villain in the plot because the "opium monopoly" that is responsible for the auction sales is a state monopoly and is allowed to flourish because it means millions of pounds annually in revenue.

We are told that the Harrison Act can only control the distribution of opium that comes to the United States through recognized agencies. There is, however, a considerable illegal traffic with the smuggled drug, and government agents often find themselves at a loss to cope with this situation. We are therefore concerned with the primary source of our opium supply and must be particularly interested in the "opium monopoly" and its monthly auction sales at Calcutta.

It would appear from Ellen LaMotte's book that Great Britain must experience a change of heart and alter her policy with regard to the opium traffic, if the world is to be relieved of a great menace.

Since Gladstone's time, and before, serious exception has been taken by many leaders of English thought to Great Britain's opium policy. The time is probably not far distant when England will do her full duty to herself, to her wide-flung dominions, and to the world at large by permitting the manufacture of opium for medicinal purposes only. The publication of Ellen LaMotte's book should hasten the much desired day.

C. M. HINCKS.

The Canadian National Committee for Mental Hygiene.

REPRESSED EMOTIONS. By Isador H. Coriat, M.D. New York: Brentano, 1920. 213 p.

This book is a very readable and acceptable addition to the rapidly developing literature on psychoanalysis. The author follows closely the Freudian concept of psychological mechanisms of character formation, and from this point of view has condensed into a small book a very satisfactory exposition of the subject for the lay student. There are several statements, rather dogmatically made, which may still be considered controversial, but the valuable suggestions appearing all through the book can only stimulate the reader to further inquiry. Although one is frequently disappointed at the rather brief discussion given many interesting phases of the subject, one must bear in mind that this book is evidently written for the beginner, with whom too much detail would be out of place.

The author is frankly making an appeal to place the subject of psychoanalysis on a very high ethical plane, and to the reviewer he has succeeded admirably. One cannot read his book without being convinced that no science or art, with its proponents, comes nearer to the highest ethical standards or ideals of modern civilization than that of psychoanalysis, and that the successful analyst must be at the opposite pole from charlatanry with all that that term implies.

The statement, "Through psychoanalysis, the mind is dissected and the hidden motives and sources of human conduct laid bare," gives the reader the author's concept in a word, and his inspiration becomes clear when he says, "The future of psychoanalysis will be a highly moral task of great educational value. It will teach the individual, and through the individual the race, that the Utopia comes from within, and as this inner adjustment to reality is perfected, mankind will advance to higher ideals of social and ethical justice."

LOREN JOHNSON.

St. Elizabeths Hospital, Washington.

THE COMMUNITY HEALTH PROBLEM. By Athel C. Burnham, M.D. New York: The Macmillan Company, 1920. 149 p.

This small volume is a summary of existing health measures and activities as they apply to community welfare. It contains sixteen brief chapters with a list of references and an index appended. It is written in simple style easily within the grasp of any one.

Each chapter deals with a subject related to community welfare. Various surveys are quoted, showing the extent of illness, which is given as the chief factor in poverty. In treating the community's illness, the author believes the private physician is a failure, in view of which better facilities are recommended for rich and poor alike. Various health departments are well considered, public health nursing is given proper emphasis, and state, private, and community endeavors in better health campaigns are discussed. The chapter on workmen's compensation insurance is clearly written. Compulsory health insurance and state medicine are favored, the former as a remedy for poverty arising from illness and the latter as a means of emphasizing prevention rather than cure, reversing the existing order; then, too, the unattended poor would have the same consideration as the rich. Health centers are intelligently discussed, as well as the social-unit plan in its experimental stage. The chapter on tuberculosis contains the usual outline for attacking the problem and some statistics. Social hygiene and rehabilitation of the disabled are considered, also, much of this discussion being devoted to federal activities, some of which are questionably assured by present government plans. The last chapter is devoted to endowed health demonstrations.

Those who favor the further socialization of medicine will agree with the author's opinions; for the rest, the material contained in the book will prove useful to public-health workers and others interested in the health of the community who wish a review of this information in condensed form. But those who are in touch with current literature and activities in this field will find little that is new or original, and those who believe that there is a mental problem in the community will be keenly disappointed, for the author in a few words relegates the insane to a scrap heap along with sufferers from advanced tuberculosis, inoperable cancer, and so on.

The importance of community health work cannot be exaggerated, but more beneficial results are to be expected when the various phases are recognized and correlated, and in doing this we cannot afford to lose sight of that phase which affects the more basic social problems—mental health.

Ralph P. Truitt.

Illinois Society for Mental Hygiene.

Traveling Publicity Campaigns; Educational Tours of Railroad Trains and Motor Vehicles. By Mary Swain Routzahn. New York: Russell Sage Foundation, 1920. 151 p.

The author has deftly assembled a useful fund of information concerning the technic of conducting educational publicity operations on wheels. The indications and contra-indications for such tours are ably discussed. The importance of carefully planned advance advertising and organization, the necessity of emphasizing the goal idea, and the need of follow-up work if results are to be expected, are all covered in a thorough manner.

The book contains detailed descriptions, illustrated by photographs, of exhibits, demonstrations, motion pictures, and other campaign material which have been housed and transported from town to town by means of trains, trolleys, motor trucks, and even motor cycles. There is an appendix which lists and describes all such exhibits, as well as a carefully compiled bibliography of literature relating to the subject. This review of the practical experience of those who have conducted such activities is made more valuable by the author's observations and comments.

The reviewer believes that the importance of traveling publicity campaigns depends first on the novelty of such operations and second on the increased accessibility to out-of-the-way localities. The arrival of an educational caravan in a small town immediately arouses interest along Main Street, while such a caravan might parade through the thoroughfare of a larger city and receive hardly a passing thought from those who see it. The arrival and departure of anything is an event in a small town; traveling publicity caravans essentially arrive and depart, and therefore are successful in arousing interest in the reverse ratio to the size and accessibility of the town.

Not only is this little book an interesting account of a certain phase of publicity activities, but it is so well written that it stimulates in the reader the desire to cover facts with that form of emotional cement necessary to make them stick in the minds of an audience.

William B. Terhune.

Connecticut Society for Mental Hygiene.

THE MAN OF TO-MORROW; A DISCUSSION OF VOCATIONAL SUCCESS WITH THE BOY OF TO-DAY. By Claude Richards. New York: Thomas Y. Crowell Company, 1917. 296 p.

This book is divided into several sections, as follows: *The Need of Vocational Guidance, The Importance of Specializing, The Need of a Broad Foundation, Choosing a Vocation, Representative Vocations, Avocations, General Conditions of Vocational Success, Appendix.* These usually are divided into several chapters, such as, *Earning a Livelihood, Specialization—The Key of Success, Vocational Guideposts, Determining Adaptability, Education—The Foundation of Vocational Success.*

Certainly after reading this book the boy of to-day will have an excellent idea of the possibilities, rewards, and difficulties of the various vocations to which he may have turned his attention. He will find that the author has presented advantages and disadvantages in a fair and impartial way. He will have the opportunity of gaining much knowledge upon the question of vocational choice, but, unless he is well educated and has had a certain amount of worldly experience, he will have difficulty in understanding or of fully appreciating much that is set forth. A simpler and briefer presentation of many of the ideas expressed would prove of greater value to the boy of to-day. The boy's father will probably derive many ideas and certainly gain a knowledge of how to present the subject of vocational choice to his son, but should he ask the boy to read this book, it is probable that the reading will be so prolonged that it may not be accomplished until the boy approaches maturity. Perhaps this is a slur upon the boy of to-day, but it seems to the reviewer that if this book were boiled down to a quarter of its length, it would be far more attractive to youthful readers.

It is also doubtful whether the boy can carry out the self-analysis that is suggested without the assistance of the counselors recommended—parent, teacher, vocational counselor, and intimate friend—although "the information is for the boy's own enlightenment. If he submits his notes to any other person, it will only be for the purpose of obtaining help, and in every way confidential." Self-analysis is such a difficult matter and so apt to be unreliable that it seems hardly fair to thrust so much responsibility upon the boy. Yet a statement like the following seems eminently true and proper: "Now it is easy to tell a young man that if he has certain natural characteristics, he will succeed in a particular vocation; but the really big task is to determine what those major qualities are. One can only say: he should study himself persistently and frankly; he should not reach a hasty conclusion; he should get the honest advice of those who know him intimately."

It may also be said that the reviewer's hopes of a real contribution to vocational psychology which were aroused upon first glancing over the contents of the book were not fulfilled. But perhaps these objections represent too much "one man's opinion." Certainly they should not cause one to lose sight of the excellence of the book as a whole.

WILLIAM R. DUNTON, JR.

Sheppard and Enoch Pratt Hospital.

MENTAL SELF-HELP. By Edwin L. Ash, M.D. New York: The Macmillan Company, 1920. 119 p.

The author states that the object of this book is to summarize in a practical way reasonable methods of obtaining self-help through the exercise of one's own mental powers. He advocates that this be carried out through the process of self-suggestion. Very definite instructions are given in the form of exercises and summarized conclusions as to the technic of auto-suggestion. A strongly religious trend permeates the entire book. The author asserts that "man is recognized as having spirtual as well as mental and physical attributes, which bring man into touch with that Principle which is the ultimate source of all powers, of all life, and of all healing."

The book has no new thought or philosophy to offer to its readers. Much that it contains is contrary to present-day psychiatric knowledge. It has no educational value and falls into that group of "proprietary publications" analogous to proprietary drugs—inasmuch as it will do no good and may do harm.

WILLIAM B. TERHUNE.

Connecticut Society for Mental Hygiene.

PROCEEDINGS OF THE INTERNATIONAL CONFERENCE OF WOMEN PHYSICIANS. New York: The Women's Press, 1920. 6 vols.

The International Conference of Women Physicians held at New York City in the fall of 1919 was an event of importance both because of the nature of the conference and because the program arranged was unusually rich in subject matter. One does not readily recall a medical program that has considered so fully medico-social problems. The program was particularly interesting to mental hygienists because of the very considerable attention given to the problems of nervous and mental disease and their social consequences.

The papers read at the conference have now been printed in six pamphlet volumes as follows:

1. General Problems of Health.
2. Industrial Health.
3. Health of the Child.
4. Moral Codes and Personality.
5. Adaptation of the Individual to Life.
6. Conservation of the Health of Women in Marriage.

Volumes three, four, and five will be found particularly valuable to those interested in mental hygiene, among the contributors being Dr. William A. White, Dr. Edith R. Spaulding, Dr. John T. MacCurdy, Dr. G. Stanley Hall, Dr. Horace W. Frink, Dr. Lucile Dooley, Dr. Max J. Exner, Dr. Edward J. Kempf, Dr. Constance Long, Dr. Esther L. Richards, Dr. George S. Amsden, Dr. Eleanor Bertine, and Dr. Jessie Taft.

FRANKWOOD E. WILLIAMS.

The National Committee for Mental Hygiene.

OLD AT FORTY OR YOUNG AT SIXTY. By Robert S. Carroll, M.D. New York: The Macmillan Company, 1920. 147 p.

This book deals with truisms and what might seem at first glance commonplaces. Eat properly, exercise regularly, play a little, sleep as necessary, cultivate mental poise, and you will defer the ravages of old age, are the principal points. And yet as one reads one is convinced that Dr. Carroll has stated these salient principles of correct living with something of the evangelistic spirit. The reviewer, at any rate, finds himself resolving to turn to tennis again next summer, so insistent is the advice and so attractive the hoped-for result.

The book will be welcomed by the class of readers for which it is planned.

A. WARREN STEARNS.

Massachusetts Society for Mental Hygiene.

NOTES AND COMMENTS

California

Assembly Bill 598 would establish two psychopathic hospitals "with the necessary laboratories and out-patient departments to furnish facilities for the study of the nature, causes, treatment, and modes of prevention of mental diseases and abnormalities, and the dissemination of knowledge derived from such study.

"This study and educational work aim particularly at the border line and early evidences of mental derangement and look toward securing information which will assist in early recognition and treatment of such disorders at a stage in which treatment and preventive measures promise success."

The hospitals are to be conducted by a board of managers, appointed by the governor, one representative each from the academic staff of the Leland Stanford Junior University, from the state board of charities and corrections, from the state hospital service, and from the regents of the University of California.

The director of each hospital shall be appointed by the board of managers on nomination by the regents of the University of California. The directors must be psychiatrists and shall have entire supervision of the medical care, study, and treatment in these hospitals. They shall also give instruction in nervous and mental diseases to students.

Equal teaching and research privileges shall be granted to all class A medical schools in the state. Definitions and regulations of these privileges shall rest with the director of each hospital.

The sum of $800,000 is appropriated for a period of two years, one-half to be expended for land, construction, and equipment for each hospital with its laboratories and out-patient department. One hospital is to be located at or near the University of California medical school and the other in or near the city of Los Angeles. For maintenance of these two hospitals, there is appropriated for the second year of the biennium $200,000, one-half of this amount for each hospital. This sum is exclusive of expenses connected with the teaching and scientific research mentioned above. Patients who are able to pay shall be obliged to do so and the money thus collected shall also be available for maintenance purposes.

The following provision is included in Senate Bill No. 394, introduced in the present legislature:

"Whenever any insane prisoner held under observation for the purpose of determining his mental condition is being taken to or from any hospital, jail, courtroom, or sanatorium, such person shall be accompanied by a trained medical attendant."

Connecticut

A new Children's Code has been submitted to the General Assembly of Connecticut. This code is the result of a study made by a special commission appointed by the governor in accordance with an act of the 1919 legislature. This commission was authorized to investigate the laws, conditions, and practices of Connecticut and other states and countries relating to dependent, neglected, defective, and delinquent children, and to embody in its report a proposed code of laws for child welfare. The recommendations of the commission are principally along three lines: the creation of a bureau of child welfare, the establishment of a juvenile court and probation system, and the organization of a division of special education and standards under the state board of education. This latter provision would give to the state board of education the power to arrange for the training of children who are below normal mentally. This division would have supervision of the education of all children from four to sixteen years of age who are legal charges of the state institutions for children or of any child-caring institution or agency licensed by the bureau of child welfare, and of all children in special classes or special schools established in accordance with the provisions of the code.

Other sections of this code would amend acts relating to the commitment to and parole from the Mansfield State Training School and Hospital, the state institution for mental defectives and epileptics.

The report recognizes that dependency and delinquency are frequently associated with mental subnormality; also that defective delinquents constitute a group requiring specialized treatment, that the defective delinquent should be differentiated from the reformable delinquent of relatively normal intelligence, and that the uncared-for mental defective may become a burden if not a menace to the community.

The report estimates the mentally defective children in the state at 2,500.

One section gives the Juvenile Court the power, in its discretion, to establish the status of "vocational probation," instead of commitment to an institution, in the case of certain types of defective children. These children are given suitable employment and are under the supervision of probation officers of the court.

A registration to determine the number of mentally and physically handicapped children is authorized. One section of the code provides that the state shall share with local communities the expense of maintaining special classes for these children. Special classes are made permissive by one section, but mandatory on the petition of parents.

The code recognizes that there is a psychopathic condition in the case of many sex offenders and authorizes a psychiatric examination in some instances.

The report shows evidence of very careful study of the methods of caring for children in the state and a thorough understanding of the needs. It is published in two volumes, the first volume containing the recommendation and the code of suggested laws, and the second presenting summaries of the findings upon which the recommendations were based.

Massachusetts

A bill to authorize the department of mental diseases to provide for the interstate transfer of indigent insane persons has been presented to the 1921 legislature. It would give the department the right to enter into an agreement with the corresponding board or commission of any other state for the transfer of any indigent insane person from one state to another where, after a full investigation of the facts in each case, he may be deemed to belong. In making such transfers, the department must employ nurses and attendants, as far as practicable, instead of officers of the law, and female nurses or attendants would accompany female patients.

House Bill 795 provides for state aid in the transportation of certain visitors to state institutions, whereby the parents, children, guardian, or relative of an inmate, provided such persons are in needy circumstances, may upon application to the department in charge of the institution receive transportation tickets at half rate. The department procures the necessary tickets, the visitor paying one-half and the deficiency being made up from the state treasury. Such persons may not receive tickets in this way oftener than once a month and must reside more than ten miles away from the institution.

Another bill, relating to alleged insane persons, states that any person whose sanity is questioned and who has not the means to hire experts shall be furnished competent mental experts by the court before which he is brought.

Two bills recently introduced to amend the laws relating to divorce would make insanity a cause for divorce.

Minnesota

A bill to establish a state psychopathic hospital has been introduced in the present legislature. This hospital is to be located at the University of Minnesota and to be administered and conducted by the board of regents of the university.

The regents of the university are to appoint a medical director and such other officers and employees as are necessary. The duties of the medical director are defined as follows: "to supervise and direct the medical care and treatment of all patients in the state psychopathic hospital; carry on and direct investigations into the nature, causes, and cure of abnormal mental conditions; ask for and be entitled to receive the coöperation of all experts in the employ of the university, such as physicians, surgeons, pathologists, psychologists, sociologists, and X-ray specialists; seek to bring about systematic coöperation between the state psychopathic hospital and all state institutions under the jurisdiction of the board of control, so far as these institutions may have in their custody defective persons or persons afflicted or supposed to be afflicted with any other abnormal mental condition; visit from time to time said institutions upon request of the respective superintendents thereof or upon request of the board of control; and may advise the medical officers of such institutions or the board of control or any court, on request, in subjects relating to abnormal mental conditions."

The state psychopathic hospital is designated as a place of temporary care to which any probate judge may send mental cases. The board of control may transfer patients from any institution under its control to this hospital for observation and treatment. Persons who are afflicted or supposed to be afflicted with any abnormal mental condition may be admitted to this hospital under such rules as the board of regents of the university may adopt. In every case, however, the consent of the superintendent of the university hospital must be obtained before any patient is sent to the state psychopathic hospital.

In connection with the hospital there would also be an out-patient department through which mental cases less pronounced than those thought proper for hospital residence would be received and treated.

This bill carries an appropriation of $275,000 for the construction and equipment of the psychopathic hospital.

Three bills relating to and regulating marriage and marriage licenses have recently been introduced in the legislature. One of these bills contains the following provision:

"No marriage shall be contracted while either of the parties has a husband or wife living, nor within six months after either has been divorced from a former spouse; nor between parties who are nearer of kin than second cousin, whether of the half or whole blood, computed by the rules of the civil laws; nor between persons either one of whom is epileptic, imbecile, feebleminded, insane, an habitual drunkard, affected with a venereal disease, or addicted to the use of opium, morphine, or cocaine."

A bill authorizing the sterilization of mentally defective or insane persons who have been admitted to institutions maintained wholly or in part by public expense has been presented before the 1921 legislature. This bill would apply to those patients by whom procreation would be deemed inadvisable by a board consisting of the board of the institution and the physician or surgeon in charge. If, in the judgment of the board, procreation would produce children with an inherited tendency to insanity or feeblemindedness, and there is no likelihood that the condition of the patient will improve to such an extent as to render procreation advisable, or if his condition would be improved thereby, the operation of vasectomy, salpingectomy, or any improvement on these operations may be performed. Thirty days' notice must be given to the parents or guardians. If they object, the matter may be referred to the probate court of the county in which the institution is located, where the question of mental defectiveness or insanity and the necessity for the operation shall be determined.

Missouri

A number of bills of interest have been introduced in the 1921 legislature. They are fostered by the Children's Code Commission and are bills that failed of enactment in the 1919 legislature. Many of the bills presented by this commission and its predecessors were passed by the 1917 and 1919 legislatures, as indicated in the April and July, 1919, numbers of MENTAL HYGIENE.

One of the bills reintroduced this year would establish a bureau of mental defectives, to be established in the extension division of the University of Missouri. The functions of this bureau are outlined as follows:

"The investigation, examination, and classification of, report upon, and recommendation concerning the education, treatment, and care of persons suspected of being feebleminded, and of children who may be otherwise mentally, morally, and educationally handicapped . . . to examine and certify children proposed by school authorities for special classes for the feebleminded; and to inspect the instruction, equipment, and teachers in the special public classes for blind, deaf, feebleminded, backward, crippled, and speech-defective children, and in the Missouri School for the Deaf at Fulton, the Missouri School for the Blind at St. Louis, the Colony for the Feebleminded and Epileptic at Marshall, the Missouri Reformatory and Missouri Training School for Boys at Boonville, the Industrial Home for Girls at Chillicothe, the Industrial Home for Negro Girls at Tipton, and similar institutions which may be hereafter established."

Other bills presented under the same auspices would prohibit the marriage of mental defectives, revise the law for commitment to the state institution for mental defectives, making it mandatory, extend the provision for special instruction in the public schools to include classes for speech defectives, backward children, and those on the border line of mental deficiency, but not feebleminded. A law enacted in 1919 established special classes for the feebleminded (pages 287 and 288, April, 1919, MENTAL HYGIENE). Another bill would vest the supervision of the instruction in all the state schools for the deaf, blind, feebleminded and epileptic, the reformatories, training schools, and industrial homes, in the state superintendent of schools.

Montana

A bill authorizing the sterilization of inmates of institutions for the insane and feebleminded failed of enactment in the 1921 legislature. This bill would have allowed the performance of such operation for the prevention of procreation as was deemed safest and most effective, upon those inmates by whom procreation seemed inadvisable and in whose condition there was no likelihood of improvement. The committee to determine these points would have been composed of two skilled surgeons and the superintendent or chief physician of the institution.

New Jersey

Much interest is shown in providing a state institution for mentally defective children in the northern part of the state. This movement is backed by the medical profession, juvenile-court judges, police departments, probation officers, and various clubs in different cities. New Jersey has two other institutions for mental defectives, one caring for males and the other for females, but the present facilities are inadequate, and there is a long waiting list, especially from the northern part of the state. Two bills have recently been introduced to provide for an institution in this part of the state, one carrying an appropriation of $400,000 and the other $300,000.

New York

A bill recently introduced in the legislature would convert the state reformatory at Napanoch into a state institution for the care, training, and treatment of mental defectives. There would be committed to this institution male mental defectives over sixteen years of age who have been charged with, arraigned for, or convicted of criminal offenses. Male inmates of a state prison, reformatory, or other penal or correctional institution who are over sixteen years of age and are found to be mentally defective may be transferred to this institution.

By the terms of a concurrent resolution of the senate and assembly there would be created a commission or commissioner on mental hygiene, which would visit and inspect all institutions for the care and treatment of the insane, epileptics, and mental defectives. This commission would take over the duties of the present State Hospital Commission and the Commission for Mental Defectives. If this measure is approved, it must be submitted to the people at the next general election.

Oregon

A bill passed by the 1921 legislature, which will be submitted to the voters at the next general election, requires all persons applying for a marriage license to have an examination as to their health in regard to contagious or communicable venereal disease and their mentality. If one or both of such applicants fail to pass the health and mental tests, they shall not be permitted to marry unless one or both are rendered sterile. The examinations must be made by a regularly licensed competent physician, whose certificate must be made under oath, and in addition to containing a statement as to the mental qualifications of the applicants, must show the educational qualifications of the physician.

Chapter 216, 1921 Laws of Oregon, approved February 23, authorizes the Oregon State Board of Control, in coöperation with the United States Bureau of Immigration, to arrange for the deportation of all alien public charges. The board must also return all non-resident public charges to the states in which they have legal residence. The term ''public charges'' applies to all persons now confined in or who may be later admitted or committed to any public institution in the state.

The board may enter into an agreement with any state for the mutual exchange of public charges who are non-residents. All expenses incurred in returning such persons to another state shall be borne by the state of Oregon, but the expense of returning residents of this state shall be paid by the state making the return.

Whenever an insane person is brought into Oregon for treatment at a hospital or sanitarium caring for such patients, the hospital or sanitarium must be responsible for his return, if he is discharged without having recovered.

Pennsylvania

A bill has recently been introduced to create a department of public welfare composed of five bureaus—charities, mental hygiene, delinquency, children, and finance. At the head of the department would be a commissioner of public welfare, with a director for each bureau. The commissioner would be appointed by the governor with the consent of the senate, and the directors by the commissioner, with the advice and consent of the governor. This act would abolish the existing Board of Public Charities, the Committee on Lunacy, and the Prison Labor Commission.

The bureau of mental hygiene would have jurisdiction over all institutions, houses, or places, within the jurisdiction of the department, in which persons of unsound mind are detained. It must adopt and publish a schedule of classes of institutions and places within its jurisdiction and supported by the commonwealth in whole or in part, and prescribe minimum standards for care and treatment and minimum rates to be charged. It must visit and investigate every such place at least once a year. It would require detailed reports from all these places with respect to maintenance, care, training, and condition of all persons of unsound mind.

South Dakota

A State Commission for the Control of the Feebleminded has been created by a law approved March 3, to be effective July 1, 1921. This commission is to consist of the superintendent of the state institution for mental defectives, as chairman; one physician, one psychologist, one sociologist, and one lawyer, to be appointed by the governor.

The purpose of the act is to provide that all feebleminded persons residing within the state shall become permanent wards of the state and shall be segregated to prevent reproduction.

Power to make all necessary regulations pertaining to the segregation, care, and control of feebleminded persons, not in conflict with the laws of the state, is given to this commission.

The commission is authorized to make a survey of all state institutions and of the state generally to ascertain the persons who are feebleminded and subject to the provisions of this act. Parents of feebleminded children and teachers are expected to report them to the commission.

The sum of $8,000 is appropriated to carry out the purposes of the act.

Utah

A bill authorizing admission to the state mental hospital of persons making voluntary application for treatment has failed to pass.

Canada

The Speedwell Military Hospital, at Guelph, Ontario, formerly the Ontario Reformatory, is to be converted into a hospital for the criminal insane. Extensive alterations are being made, and it is planned to develop this hospital along lines similar to the Matteawan State Hospital, New York.

THE NATIONAL COMMITTEE FOR MENTAL HYGIENE MOVES TO NEW QUARTERS

Coördination of the work of important voluntary national health agencies will become a reality on May 1, when a number of these organizations will take possession of two floors of the Penn Terminal Building, in Seventh Avenue at Thirty-first Street, New York City.

Each organization will retain full autonomy, and the new arrangement is in no sense a merger. It is an effort to bring the organizations together for economy in overhead expenses and for coöperation in health programs. A Common Service Committee has been organized, composed of representatives of the agencies originally interested in the project.

This is a further step in the development of the National Health Council organized last fall. The council begins its functioning in coöperation with the joint establishments of the health agencies with New York offices, where they may work together for the betterment of health work and the prevention of disease in the United States.

The present direct participating members of the National Health Council are the American Public Health Association, American Red Cross, American Social Hygiene Association, Conference of State and Provincial Health Authorities of North America, Council on Health and Public Instruction of the American Medical Association, National Child Health Council (representing indirectly at present its own constituency not otherwise a part of the council—namely, the American Child Hygiene Association, the Child Health Organization of America, and the National Child Labor Committee), National Committee for Mental Hygiene, National Organization for Public Health Nursing, and the National Tuberculosis Association. As a conference or advisory member of the council, there is the United States Public Health Service.

On the fifteenth floor of the Penn Terminal Building will be the offices of the American Social Hygiene Association, The National Committee for Mental Hygiene, the National Organization for Public Health, coöperating with the American Nurses' Association and the League for Nursing Education, and the National Tuberculosis Association.

On the sixteenth floor there will be offices for the American Public Health Association, formerly in Boston; the Bureau of Social Hygiene; the Child Health Organization of America; probably the liaison office of the United States Public Health Service; the National Health Council, with the Common Service Committee; the Maternity Center Association; the New York Diet Kitchen Association; the New York Community Service; and probably the American Society for the Control of Cancer.

Social Service in Hospitals and Clinics

The report of the committee appointed by the trustees of the American Hospital Association in the spring of 1920, for the purpose of surveying and offering recommendations upon social service as a phase of the activities of hospitals and dispensaries, has recently been printed in *Hospital Social Service.* The committee was composed of Michael M. Davis, Jr., Chairman; Dr. Louis B. Baldwin, Miss Ida M. Cannon, Miss Lillian Clayton, Miss Ruth V. Emerson, Dr. S. S. Goldwater, Miss Edna Henry, Dr. Joseph B. Howland, Miss Mary C. Jarrett, Porter R. Lee, Dr. James A. Miller, Rev. Father John O'Grady, Fred M. Stein, Miss Katherine Tucker, Miss Mary E. Wadley, Dr. A. R. Warner, and Dr. Frankwood E. Williams. The survey was made by Dr. Anna M. Richardson.

The report covers such items as function and organization, education of social workers, education of psychiatric social workers, relation of the hospital or dispensary social service to the medical care of the patient, assistance rendered the hospital or dispensary in its administrative activities, and responsibility of the hospital social service to the community. Under the heading of *Function* the report states: "(a) The basis of hospital social service is its relation to the medical care of the patient. The restoration and maintenance of health depend in many instances, not only on accurate diagnosis and direct medical treatment of pathological conditions of the body, but also upon dealing with the patient's personality, and upon the alteration or adjustment of his home conditions, occupations, habits, and community relations. The wise physician understands the connection of social and medical elements and seeks a knowledge of both before determining his final program for treatment. Within the medical field itself, the advance of science requires the physician to call upon specialists in many branches, upon the laboratory and the X-ray, in order that he may be able to secure all necessary data and judgments about his patient. The social worker is called upon to secure facts, and to aid in interpreting them, in order to provide a basis for a plan of treatment which takes into account both the medical and the social elements. The social worker also aids in the carrying out of treatment.

The merging of the social work with the medical work is essential to effective use of the social worker. Social treatment must have as its aim the promotion or accomplishment of the doctor's plan of treatment—a plan that has taken into consideration the personal and environment elements as well as the medical. Entering more into detail, it may be said that it is a primary duty of social service in a hospital or dispensary to assist in the cure and prevention of disease in individual cases by such activities as:

1. Discovering and reporting to the physicians facts regarding the patient's personality or environment which relate to his physical condition.
2. Overcoming obstacles to successful treatment such as may exist or arise in his home or his work.
3. Assisting the physicians by arranging for supplementary care when required.
4. Educating the patient in regard to his physical condition in order that he may coöperate to the best advantage with the doctor's program for the cure of the illness or the promotion of health.

"(b). The primary work of hospital social service, therefore, is work with individual patients. In this respect, the work corresponds to that of the medical service of the same institution.

"Work with individual patients, whether by physician or social worker, is called case work, meaning that all the relevant facts (medical, social, or both) about the individual must be secured, analyzed, and interpreted as a basis for a diagnosis of the disease or problem and a program for dealing with it. The body of facts constitutes the 'case.' It is hardly necessary to add that social case work with individual patients requires and implies knowledge of the patient's family and of its community relations.

"No hospital can, in the opinion of the committee, be regarded as possessing a social-service department unless the primary function of assistance in the medical care of the patients is practiced as one of the main activities of the department. The size of the department (whether one worker or twenty) has no bearing on this judgment."

After discussing certain administrative activities, the report continues:

"(c). As with hospital and dispensary, so social service in a number of properly equipped and favorably situated institutions can and should participate actively in education, in the training of medical students, of nurses, and of hospital social workers themselves; and social-service departments in all institutions should have educational interests and by-products. Likewise, medical-social research should be pursued, collecting and interpreting data which will shed light upon the social relations, the causes, and the means of dealing with disease."

As to *Organization* the report says, "As a fundamental general principal, social service should be organized as a department of the hospital," and, "This form of organization implies the direct responsibility of the head worker of the department to the superintendent or chief executive officer of the hospital."

In the matter of *Education,* the committee believes that the elements that should be derived from training and experience are five in number:

"1. Knowledge of the chief diseases, groups of diseases, and health problems, primarily in their social implications.
2. Understanding of the social, industrial, and economic problems as they affect family life.
3. Knowledge of the purposes and activities of the chief public and private health and social agencies and of legal and community conditions which affect health.
4. Understanding of the traditions and customs of the medical profession and of medical institutions.
5. Ability to utilize both knowledge and personal qualities in attaining understanding of people and practical results in coöperation, guidance, and leadership."

The committee further states that "any course of training for hospital social service should include the two elements of didactic instruction and practical experience under supervision. These two branches should be closely related as parts of one curriculum. There is a certain parallel between the methods of teaching medical students in the hospital or dispensary and the methods of teaching social workers. Both the medical student and the medical social worker need to learn to deal effectively with individual patients. Both are in this sense case workers. The acquirement of this ability depends in each instance upon a combination skill, applied by an adequate personality; and the education which shall make this acquirement possible must effect the right combination of the didactic and the practical elements. The parallel should not be carried too far."

The survey disclosed the fact that there is at the present time considerable diversity in the training of social workers and recommended that the American Hospital Association form a committee on training for hospital and dispensary social service, composed of physicians, nursing educators, hospital social workers, and educators in general social service, to make further studies and recommendations upon this subject.

FUNCTION AND TRAINING OF THE PSYCHIATRIC SOCIAL WORKER

With the rapid development in the field of psychiatric social work, it has seemed important that an effort be made to define the function of the psychiatric social worker and to determine a standard of training. That these subjects might be discussed, a conference of those engaged in the training of psychiatric social workers and those interested in the services of such workers was called by The National Committee for Mental Hygiene. There were present: Dr. E. Stanley Abbot, Medical Director of the Mental Hygiene Committee of the Public Charities Association of Pennsylvania, Philadelphia; Dr. C. Macfie Campbell, Director, Boston Psychopathic Hospital; Professor F. Stuart Chapin, Director, Smith College Training School for Social Work, Northampton, Mass.; Mr. Everett S. Elwood, Secretary, New York State Hospital Commission, Albany; Miss Ruth V. Emerson, Director of the Bureau of Medical Social Service, The American Red Cross, Washington, D. C.; Dr. Bernard Glueck, Department of Mental Hygiene, New York School of Social Work, New York City; Miss Beatrice M. Gosling, Director, Psychiatric Social Work, Department of Health, Newark, N. J.; Miss Edith A. Howland, Field Worker, Atlantic Division, The American Red Cross, New York City; Miss Mary C. Jarrett, Associate Director, Smith College Training School for Social Work, Northampton, Mass.; Miss Suzie L. Lyons, Social Worker, Henry Phipps Psychiatric Clinic, Baltimore, Md.; Dr. Thomas W. Salmon, Medical Director, The National Committee for Mental Hygiene, New York City; Miss Gertrude C. Scott, U. S. Public Health Service, New York City; Dr. William B. Terhune, Medical Director, Connecticut Society for Mental Hygiene, New Haven; Dr. Frank D. Watson, Director, Pennsylvania School for Social Service, Philadelphia; Dr. Frankwood E. Williams, Associate Medical Director, The National Committee for Mental Hygiene, New York City. Dr. Campbell, as Chairman of the Committee on Education of The National Committee for Mental Hygiene, served as chairman of the conference.

It was agreed that the psychiatric social worker was essentially a social case worker who has had special training in social psychiatry and in the application of psychiatry to social problems and case study and treatment. Her function was defined as one of assistance to and coöperation with the physician in restoring the patient to health and social adjustment; specifically (1) to facilitate admission to hospital or clinic and to facilitate continuance of treatment by removing personal and family prejudices in regard to treatment; (2) to bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment; (3) to assist in carrying out the treatment advised; (4) to interpret the function of the hospital or clinic to the patient, the family, and such community organizations as are interested in the patient; (5) to undertake social investigations that will contribute to medico-social research.

In the discussion it was emphasized that in her study of the social factors involved in the case—family and neighborhood relationships, economic conditions, occupational environment, recreational and other diversional opportunities, or lack of them, and the like—the social worker has a distinct and unique contribution to make to the understanding of the patient; that the relationship between the physician and social worker is not comparable to that between physician and nurse; that, in the field of her special experience and training, the social worker should be encouraged to the use of initiative, and that, in the carrying out of treatment outlined by the physician, she should be encouraged to use her judgment and experience, under the guidance and general direction at all times, however, of the physician.

It was agreed that an applicant for training in psychiatric social work should have had a college education or its equivalent. It was agreed that it was not practicable to attempt to train such workers in a course of less than nine months, and that the course should be preferably eighteen months; that the course should include both didactic and field work; that the field work might be given either concurrently with the didactic work or apart from it; that the field work should be under careful and expert supervision and that, if it is given apart from the didactic work, provision should be made for conferences at regular intervals and concurrent reading; that in the division of time between the didactic and field work a minimum requirement of field work should be six months.

For Callouses on Your Feet See the Orthopedist; For Nervousness Take Petroleum Oil

An eminent health commissioner of one of our largest cities conducts a column on health that is syndicated to various newspapers. While breakfasting in Montgomery, Alabama, recently, we read in the *Montgomery Advertiser* an interesting account of anthrax infection and then turned to the column in which the commissioner answers inquiries. Among the questions and answers we found these two:

> Q.—I am 47 years old and am troubled very much with callouses on my feet. I bathe them with hot water and soda two and three times a week and then cut the callouses away. I get relief for a short time only. I have to be on my feet in order to earn a living and have tried several remedies to no avail.
>
> A.—I would suggest that you consult an orthopedic clinic or your own physician.

Q.—Kindly advise me what I can do for nervousness, as I am very nervous. I am a young man 24 years old.

A.—Nervousness is sometimes due to constipation. I would advise you to take a tablespoonful of petroleum oil every night before retiring. Get regular exercise and plenty of sleep.

THE NATIONAL CONFERENCE OF SOCIAL WORK

A meeting of the National Conference of Social Work will be held in Milwaukee, Wisconsin, June 22 to 29. The following program is announced for the Mental-Hygiene Section:

SECTION MEETING I

Mental-Hygiene Problems of Normal Childhood and Youth.

In Elementary Schools.

Esther Loring Richards, M.D., Instructor in Psychiatry, Johns Hopkins University.

In Secondary Schools.

Jessie Taft, Director, Mental-Hygiene Clinic, The Children's Bureau, Philadelphia.

In College.

Frankwood E. Williams, M.D., Associate Medical Director, National Committee for Mental Hygiene.

SECTION MEETING II

Mental-Hygiene Problems of Subnormal Children.

In the Public Schools.

Meta L. Anderson, Supervisor of Special Classes, Public Schools, Newark, N. J.

In Institutions.

V. V. Anderson, M.D., Associate Medical Director, National Committee for Mental Hygiene.

In the Community.

William C. Sandy, M.D., Psychiatrist, N. Y. State Commission for Mental Defectives.

SECTION MEETING III

Mental-Hygiene Problems of Maladjusted Children.

In a Public Clinic.

Arnold L. Jacoby, M.D., 1st Asst. Physician, State Psychopathic Hospital, University of Michigan, Ann Arbor.

In School.

From the Teacher's Point of View.

Elizabeth E. Farrell, Inspector of Ungraded Classes, Department of Education, New York City.

From the Physician's Point of View.
Sanger Brown, II, M.D., Asst. Director, Classification Clinic, Neurological Institute, New York City.
In Institutions.
Herman M. Adler, M.D., State Criminologist of Illinois.

SECTION MEETING IV (Suggested joint meeting with Division IV, on time of Div. VIII.)
Educational Value to the Community of Mental-Hygiene Agencies.
The Psychopathic Hospital.
William F. Lorenz, M.D., Director, Wisconsin Psychiatric Institute.
Psychiatric Social Work.
Mary C. Jarrett, Associate Director, Smith College Training School for Social Work.
Mental-Hygiene Clinics.
H. Douglas Singer, M.D., State Alienist of Illinois.
Mobile Psychiatric Clinics.
Albert M. Barrett, M.D., Director, State Psychopathic Hospital, University of Michigan, Ann Arbor.

SECTION MEETING V
Mental Hygiene in Education.
What Teachers Want to Know About Mental Hygiene.
William H. Burnham, Professor of Pedagogy and School Hygiene, Clark University, Worcester, Mass.
The Part Mental Hygiene May Play in the Solution of School Problems.
Eleanor H. Johnson, formerly Social Worker, Bureau of Ungraded Classes, Department of Education, New York City.
Speech Disorders in School Children.
Smiley Blanton, M.D., University of Wisconsin.

At the meeting of the Division on the Family Dr. William Healy of Boston will read a paper on *The Application of Mental Tests to Family Case Work;* Dr. Marion E. Kenworthy, of the New York School of Social Work, one on *Extra-medical Service in the Management of Conduct Problems in Children;* and Miss Elizabeth Dutcher, of the New York Charity Organization Society, one on *Possibilities of Home Supervision for Border-line Women.* In the Division on Children there will be a discussion under the direction of C. V. Williams of Boston, Chairman of the Subcommittee on Standards of Care for Dependent Children, on *Admissions to Child-Caring Institutions and Societies.* In this discussion, the following questions will be considered: How much ought we to know about the child? How much do we know as a usual thing? What are some of the results of the average admission job? What values are conserved through careful admission work?

MENTAL HYGIENE, MUHLENBERG COLLEGE

Muhlenberg College, Allentown, Pa., plans to enlarge its service to teachers and health workers at the summer session of 1921 by the addition of courses in mental hygiene as related to work in education. These courses have been arranged to meet in part the need expressed at the meeting of the National Council of Education of the National Education Association at Atlantic City in March.

Courses are being arranged by Norbert J. Melville, A.M., Assistant Director of the Mental Hygiene Committee of Pennsylvania, and President of the Child Hygiene Round Table of the Pennsylvania State Educational Association. The courses will be given by Dr. Clarence A. Patten, formerly assistant physician at the Pennsylvania Hospital for Mental Disease, and at the present time instructor in the Graduate School of Medicine, University of Pennsylvania, and assistant in the Out-patient Department of the Neurological Service of the Polyclinic Hospital, Philadelphia, and by Mr. Melville.

The following courses will be offered:

1. Educational Mental Hygiene—an introductory course in the principles of psychiatry as applied to education. The problems of normal physical and mental development in childhood, youth, and maturity. These problems will be presented from the standpoint of classroom management and the growth of the teacher's personality. A critical study of the current ideas on mind and conduct.

2. Mental Mechanisms—an advanced course with consideration from a practical standpoint of adjustments, behavior, self-control, attitudes, and emotions. The problem of difficult children with special reference to maladjustments, precocity, and abnormal conduct. Open to students who have completed Course 1.

3. Group Testing—an introductory course in the principles and methods of testing intelligence and other functions. Practical demonstrations and training in standardized procedures in applying and scoring tests, including the simpler statistical treatment of results. The basis of the course will be the series of group and individual scales for pre-clinical testing and classification used in the Mahanoy Township mental-hygiene survey. Students will be required to attend demonstration mental clinics, conducted by various specialists.

4. Advanced Educational Diagnosis—a detailed psycho-educational and psychiatric study of general and specific abilities and disabilities, emotional attitudes, and difficulties, etc., with their attendant physical defects and disorders. Detailed technique and interpretation of physical and mental measurements, of medical and social studies, and

clinical demonstrations by specialists in various phases of education, psychiatry, and social investigation. Open only to advanced students.

5. Introduction to Statistical Methods, with special reference to the biometric study of the individual. The aims of this course will be: first, to prepare one to read and understand statistical reports of modern investigations in education; second, to prepare and interpret percentile tables, correlations, graphs, and individual indices; third, to develop an appreciation of the general aims, values, and limitations of statistical methods in education.

6. Mental-Hygiene Surveys of School Children—an advanced course in the organization and administration of mental-hygiene surveys of classes and school systems. Clinical and statistical interpretation of group and individual measurements and studies, both psycho-educational and psychiatric. Reorganization of school grading, promotion, courses of study, methods of discipline, and the records and reports. The principles, methods, and results of the mental-hygiene survey of the school children of Mahanoy Township and other psycho-educational surveys conducted under the auspices of mental-hygiene committees will be presented and discussed.

7. Special investigations in problems of educational mental hygiene.

During the week of June 27 to July 2, a series of conferences on the mental hygiene of childhood and youth will be conducted by Dr. Frankwood E. Williams, Associate Medical Director of The National Committee for Mental Hygiene, at which such topics as the *Opportunity for Mental Hygiene in the Rural School, The Problem of the Child Entering School, Mental Hygiene and School Conduct,* and *Mental Hygiene of Gifted Children* will be discussed by experts in these fields.

SMITH COLLEGE TRAINING SCHOOL FOR SOCIAL WORK

The third session of the Smith College Training School for Social Work begins on July 5th of this year. Owing to the large registration of new students last summer, the graduating class will be large this August. At the present time twenty-eight students are receiving their training in practice work in the courses in psychiatric social work, medical social work, and community service. Training centers have been established in Boston, New York, Cincinnati, and Minneapolis for students in psychiatric social work. Students in medical social work are in training in Boston and New York, and students in community service in Boston and Philadelphia. The students who are now in training at hospitals and settlements will return to the concluding summer session of their courses this summer, bringing with them some very interesting material gathered from their practical experience, which will be worked up into theses. The outlook for a large entering class is promising.

Dr. Frankwood E. Williams, Associate Medical Director of The National Committee for Mental Hygiene, will be in charge of the course in social psychiatry this summer and Dr. Florence L. Meredith, Associate Director of Hygiene in the Woman's Medical College of Pennsylvania, will be in charge of the courses in social medicine.

Inquiries relative to courses of instruction, tuition fees, living expenses, etc., should be addressed to The Director, Smith College Training School for Social Work, Northampton, Massachusetts.

LEHIGH UNIVERSITY EXTENSION COURSES

As an outgrowth of the courses in mental hygiene offered during the 1920 summer session at Lehigh University, there has been conducted by the extension service of the university a series of courses during the past winter. These courses have been under the direction of Norbert J. Melville, A.M., Assistant Director of the Mental Hygiene Committee of Pennsylvania. Four courses have been conducted in Philadelphia, two in Atlantic City, and one each in Mahanoy and Pottsville, Pa., Pleasantville, N. J., and Lehigh. The general plan has been for a thirty-hour course, two hours a week for fifteen weeks.

COURT CLINIC IN DETROIT

A psychopathic clinic is being established in connection with the Recorder's Court of Detroit. Dr. Arnold L. Jacoby, formerly first assistant physician at the State Psychopathic Hospital, Ann Arbor, Michigan, has accepted the position of director. The clinic will open on April 1. It will be held in the New Municipal Court Building, and the budget, voted by the City Council of Detroit, provides for the employment of psychologists, social workers, and a clerical force. The clinic appears to have the whole-hearted support not only of the judges of the court, but of the social workers and others in Detroit interested in public-service problems.

CONFERENCE IN CONNECTICUT

On January 24, 1921, the Connecticut Society for Mental Hygiene held an interesting conference in Waterbury under the auspices of the Visiting Nurses' Association. Mr. Arthur R. Kimball, President of the Society, presided over the meeting, which was well attended by social workers, heads of industrial firms, and the public at large. The speakers of the evening were Dr. P. B. Battey, Psychiatrist at the Connecticut State Prison, Wethersfield, whose subject was *Psychiatry and Mental Hygiene in the State Prison,* Dr. William B. Terhune, Medical Director of the Connecticut Society, who spoke on *The Importance of Mental Health to the Community,* and Mrs. Helen M. Ireland, Secretary of the Society, who talked on the *Social Treatment of the Mentally Afflicted.*

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NOVEMBER 1920–MARCH 1921

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MENTAL HYGIENE

VOL. V JULY, 1921 No. 3

THE RÔLE OF SITUATION IN PSYCHOPATHOLOGICAL CONDITIONS

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NOT long ago a colleague interested in psychopathology said to the writer: "I wish we could work out some of those beautiful analyses of cases one sees in current psychiatric literature. It would be so satisfying." Expressive though it is of the silent longings of many of us in moments of quick discouragement, this remark, nevertheless, forms a sort of background on which to work with a group of individuals in whom the writer has been increasingly interested. They are men and women and children whose difficulties of adaptation are for the most part associated with their respective settings of environment, habit data, temperamental friction, and all the other facts of common experience. There is nothing remarkable about their stories. Most of them have not enough associative material to form even a modest structure of word architecture in the way of analysis. Equally undramatic is the relief that can often be given to these conditions of distress and perplexity by such simple measures as ventilative discussion of the difficulty with the patient and his family, change in habits of living, corrective exercises for twists of personality expressed in sensitiveness, nagging, nervous fears of disease, day-dreaming, and many another stile over which human beings are apt to pass into the by-paths of Doubting Castle.

With one brilliant exception, the literature of psychopathology is surprisingly lacking in discussions of the rôle of situation as an etiological factor in this type of disease. In reviewing the progress of research in psychiatric medicine, one is struck by the passionate tendency to lose the individual in the mass and to gravitate toward discovery of a general cause for disorders of balance as a whole. It is only in the near past that such a general cause for psychopathological manifestations was sought exclusively in chemical and anatomical changes in the brain. From this theoretical standpoint, the etiological search has drifted to the psychogenic pole, so that to-day we find equally enthusiastic exponents of a point of view diametrically opposite, but also all-embracing in its possibilities of conquest. Between these two extremes of investigation there has gradually arisen another method of approach to the problems of etiology in this field of science. Instead of studying a patient with the unconscious determination to find an exposition of some preconceived theory, the physician is urged to study him for facts which he, as an individual case, presents. The etiological facts of this particular patient may be neurogenic or exogenic or organogenic or psychogenic or situational; they may be combinations of one or more of these factors. Upon the unbiased weighing of facts depends the outlook, good or bad. Some of them can be modified, others cannot. The criterion in every instance must always be an individual matter. To Adolf Meyer more than to any other psychopathologist is due the pioneer credit of raising the facts of concrete and specific observation to the rank of scientific data in psychiatric research. Writing in the *Psychological Bulletin* in 1907,[1] he made a plea for the reduction of dogmatic general considerations to their actual value in the life of definite patients. "Our concern," he says, "is with the event or 'doing,' not with the being or final essence. We study the relation of occurrences and experiences, and among them we find, on exactly the same ground as the rest of experiences, the occurrence of events and activities which are called mental. The fundamental principle of the non-dogmatic attitude is the adherence to a series of non-prejudicial queries which hold for all events worthy of inquiry: (1) What is the fact in question? (2)

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[1] *Psychological Bulletin,* Vol. IV, pp. 170-79, June 15, 1907.

What does the event or fact lead to, or how does it react to tests? (3) What are the conditions for its existence, or course? (4) How can it be influenced, and what is our attitude to the event?"

Without benefit of training in the traditional methods of psychopathological research, the writer of this paper began at the start with a study of case material and its intrinsic values in terms of problem and constructive assets. The facts involved take one far afield, so that even in any one human story it is hard to say whether we deal with heredity, poor environment, neurotic make-up, endocrinopathy, aberration of the libido, or other etiological constellations which bear the burden of many accusations. In the cases outlined in this paper, the facts of situation seem to play a leading rôle, as indicated by the disappearance of certain unhealthy tendencies in the presence of a setting modified to suit the individual need. The seventeen cases sketched here are taken from the Out-patient Department of the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, in which from 50 to 60 per cent of the new admissions each month are children. By reason of this emphasis on children in our psychiatric dispensary, and for the sake of uniformity of material for descriptive purposes, the writer has confined her present observations entirely to children. The seventeen children recorded in the accompanying chart (pages 462-467) were first seen in the Henry Phipps Psychiatric Dispensary during the months of September and October, 1920. They were referred, as are most of our patients, from outside physicians, from social organizations such as the Henry Watson Children's Aid and the Family Welfare Association, from schools, and also from the various out-patient departments of the Johns Hopkins Hospital, especially from the pediatric service of the Harriet Lane Dispensary. In every instance the physical condition has been passed upon by one or more physicians on the general dispensary staff of that hospital. The majority of these cases have been carefully studied by the social workers of our psychiatric service, who have made repeated visits to the home and school, listening to the stories of family and teachers and effecting that exchange of viewpoints which makes for mutual understanding and intelligent coöperation. To these students and their co-workers in local agencies is due the credit of the results recorded with regard to this group of patients.

Passing from this foreword to a consideration of the cases sketched in the accompanying tables, one is struck by the simplicity of the subject matter to which one's attention is called. The surprise is greater if one has been accustomed to associating psychiatric patients with well-formulated psychoses of Kraepelinian entities. The complaints for which these children were referred—twiching, retardation, speech disturbance, excitability, imaginary somatic distress, etc.—may or may not augur ill for the future. For the present, at least, they constitute a handicap to the start in life that cannot be ignored. The presence of "spells," for example, whether temper storms or pseudo-convulsive tricks, tends to single out the child from other children in the family and other scholars in the classroom. The watching and anxiety and special consideration of parents and teachers cannot but have its effect on the child himself. In some instances it fosters embarrassment with feelings of inferiority; in others it acts as a wedge for native aggressiveness and lack of consideration; and in every instance it focuses the attention of the child on himself with a wealth of unhealthy reactions so familiar in the psychopathology of everyday life. In reviewing the background of situations from which the above-mentioned complaints have arisen, one is again impressed by the absence of any great and startling facts, especially if one has been accustomed to associating psychopathological conditions with definite etiological factors—such as somatic disease, emotional strains of shock and conflict, and desperate adaptive problems of poverty and hardship. The situational data presented here involve such facts as poor habit training, faulty understanding of the individual child, and unwholesome attitudes of parents and teachers expressed in chronic worry, over-solicitude, nagging, repression of initiative, too much stimulation, pushing beyond native capacities, etc. Petty and commonplace facts they seem in the telling, and yet capable of producing tremendous influence on the springs of human activity.

Case Histories

C. K. (No. 1) is a boy of eight who was brought to the dispensary by his mother with the complaint that he was "backward in everything." He was teased by younger children, would give up his rights sooner than fight or argue, and sat around the house doing nothing after school. The boy slept poorly and was afraid of everything.

Examination of Patient and Situation: The patient was pronounced physically normal in the Harriet Lane Dispensary. He had a mental age of eight years plus, according to the Binet-Simon tests. In appearance he seemed bright and full of normal interests. He was in the third grade of a small private school, not being allowed to go to public school because it was "too rough." He owned a football, a baseball, and a bat, all of which were in good condition because he was allowed to use them only in the small backyard of his home. Apparently he had never had an opportunity to receive a black eye or get his feet wet. On investigation it developed that the father and mother were separated, and the latter and the patient lived with the maternal grandmother. The father was a ne'er-do-well and alcoholic, and the mother felt that the patient should be shielded from influences that might tend to develop inherited characteristics. Hence his companions and play had been carefully supervised. The child felt that in some vague way he was different from other children, and that this difference was associated with the father, who must have been a very bad man. The mother ascribed the patient's odd behavior to "nerves," which were a sure sign of tainted inheritance.

Suggested Modification and Results: An attempt was made to show the mother that this child's faulty characteristics were the product of her own solicitude and fear. It was suggested that she try a program of encouraging the patient's initiative—transfer to a larger school, right of way to playground without continued watching and fear of disaster.

The mother reports at the end of five months that the patient has not only outgrown his previous tendencies, but seems to have made up for lost time in his noisiness and irrepressibility. In appearance the boy is franker and more communicative. He speaks voluntarily of the part he is taking in games, and boasts of his prowess in having settled a personal dispute or two with "fellers bigger than I am."

M. S. (No. 16) is a boy of eight who was referred by a Hebrew charitable organization for nervousness, consisting of twisting the mouth to one side, twitching and jerking the shoulders, and blinking the eyes. The patient is one of four children. His elder brother, Joe, had nervous fears and vague imaginations which disappeared as soon as he was removed to a boarding home in the country, but reappear whenever he returns home. The mother nags at the children in loud, querulous tones and then allows them to have their own way. She is over-ambitious for their progress. The patient, for example, is in the high third grade, and as soon as he comes from school at three-thirty, he goes to a Hebrew school where he remains until after six.

Examination of Patient and Situation: The symptoms for which the patient was referred were first noticed during a brief home visit of brother Joe, and were more in evidence under special strain of discipline at school and at home. During examination the child appeared shy and silent, but as soon as his family left the room, it was easy to get him on a talking basis. His attitude toward brother Joe seemed a mixture of envy and admiration. "Joe can fish"—and the like —"and nobody hollers at him. He's nervous, too, and when he goes to the moving pictures, he can see white spots, and I can't see no spots," etc. To physical examination the patient appeared normal. His meals were irregular, and his bedtime often as late as 11 p. m.

Suggested Modification and Results: Regulation of eating and sleeping habits was advised, and also the substitution of play for the Hebrew lessons in the afternoon. The mother was urged to ignore the nervous tricks as much as possible, at least to the extent of not harassing the child concerning them.

At present writing—four months from the date of the first examination—the mother reports a discontinuance of the former complaints. The child himself gives the impression of less tension and sense of being over-stimulated. The out-door play evidently gives him a great deal of satisfaction. It is an outlet for energy in an atmosphere of abandonment free from supervision.

Discussion: In the above cases one sees two children of approximately the same age, physical status, and original mental equipment. One has had the benefit of quieter home surroundings, perhaps, and more careful supervision of living habits. Yet both display abnormal behavior that is directly the product of their environments, though the type of the reactions is quite different. C. K. reacts with indifference, sluggishness, and timidity to his mother's repression of boyish instincts to fight and play and run with the group. M. S. reacts with mild choreiform movements to the over-ambitious program of an anxious mother to whom goading is the embodiment of discipline. The object of the therapy in each case was the mother, who, with a little guidance, has been able to readjust matters for the unbalancing of which she was unwittingly responsible.

The next two cases deal with material depressingly familiar to every physician under the term "hypochondriasis." In its adult and middle-life setting, the symptoms are monotonous, the treatment is apt to be unremitting, and the individual etiology becomes year by year more drab and obscure. The following children were referred from the pediatric dispensary of the Johns Hopkins Hospital because of persistent somatic complaints for which no organic basis had been discovered.

M. S. (No. 10) is a little girl of three years who complained of pain in her knees at night, so severe that she woke crying several times each night. The condition had developed gradually during the past ten months, at first occurring two or three times a week and then becoming a nightly phenomenon. During the day the child slept a good deal, as if to make up for previous wakefulness.

Examination of Patient and Situation: Little could be obtained from the child directly. She appeared tired and sleepy—in fact took several naps in her mother's arms during the examination. The patient had always been healthy except for the present illness. There were no special developmental traits except that the child had always shown a keen imagination, imitating what she saw and heard without any encouragement. For example, a neighbor came into the house one day and told of some friction between herself and her husband. After she had gone the patient was found in another room scolding a make-believe husband in loud tones. Up to the birth of a brother fifteen months before, the patient had been the only child and her father's pet. She had slept in the parents' bed, but now slept in a crib in their room, while the baby slept with the parents. At the birth of this brother, the patient refused food for four days, beat her head against the floor, and later tried to hit the baby with a broom. The mother stated that she had outgrown this jealousy and now seemed very fond of the baby. There was no history of disciplinary troubles.

The father is a laborer who works all day, but for the past year or more he has had inflammatory rheumatism in his knees to which a great deal of attention has been paid. Since the onset of the patient's illness, both father and mother have been up with her frequently during the night, rubbing her knees and applying hot cloths for relief of the pain.

Suggested Modification and Results: The probable mechanism of this curious behavior was explained to the mother. Care was taken to show her that these activities to get the father's attention were simple outcroppings of natural initiative, appearing in an extremely imaginative child, and not early buddings of original sin. It was suggested that the patient be put to sleep in a room by herself, and that her tears be ignored without discussion or attempted argument.

The mother reports that after a week of the above régime the symptoms gradually subsided and have not reappeared thus far. It was not thought best to talk over the illness with this little patient even after the disappearance of her symptoms. The parents seem to be handling the situation wisely, especially with reference to the child's attitude toward her father and the small brother. She is not teased or "shown off," as is so often the case with sensitive, precocious children, but is quietly encouraged to spend her initiative and imagination in playing with others of her own age.

M. W. (No. 11) is a girl of eleven years who was brought by a public-health nurse for "heart trouble," which had existed for almost two years.

Examination of Patient and Situation: The patient belongs to a family subject to temper tantrums, crying spells, neurotic vomiting, etc. Her first "spell" came about the time her mother remarried after the death of the first husband. The patient resented this marriage. The stepfather is unable to support the family and is abusive to her mother. One morning while preparing for school, the patient had "words" with her mother over some matter of dressing. The patient "doubled up like a ball" and had to be assisted to bed. A doctor who was called pronounced the condition heart trouble and told the patient she might die at any time if she were not careful. He forbade her going to school or taking light exercise—such as going to the store on errands. The child spent most of her time in bed with three pillows, reading trashy books. She complained of palpitation and weakness even in walking about the house. The stepfather regarded her as an idler, and the child was often the subject of a family brawl.

Suggested Modification and Results: The mother and patient were reassured as to the supposed heart condition, and a daily routine of return to school and normal activities was outlined. The nurse volunteered to follow the case and see that the patient was gradually steered away from her previous invalid habits.

The child has now been in school since November first, and so far has had no recurrence of the former symptoms. Unfortunately this child comes from a rural district from which return to the city dispensary is hard to achieve. She has not returned since her first visit, but is being carefully followed by the public-health nurse, with whom we are in touch.

Discussion: In these two children one sees hypochondriacal tendencies arising quite naturally from their respective backgrounds. The one child at three years of age uses her constructive imagination and imitative powers to advance her importance in the circle of family and neighbors. Having once tasted the joys of special consideration, even without a clear idea of the means by which they were attained, this little girl clings to her behavior until pain and tears become realities in her world of practical experience. The other child of eleven reacts to a conflict of argument with a flurry of behavior for which she may have seen the pattern in her mother or older sisters. It needed but the professional touch of diagnosis and treatment to push this small patient into a rut of invalidism, from which she was rescued only by the long arm of compulsory education.

H. K. (No. 8) and J. D. (No. 12) exemplify psychopathological behavior which has been discussed from many standpoints. Stealing, lying, sex irregularities, the starting of fires, etc., are associated with defectiveness, "constitutional psychopathic inferiority," and the general incorrigibility of the delinquent, whether it be a social or mental disease. The conduct disorders of these two particular children have not proven as grave as the face value of the complaints seemed to indicate.

J. D. (No. 12) is a girl of seven years who was referred for incorrigibility, which consisted of stealing, untruthfulness, and temper tantrums.

Examination of Patient and Situation: No data could be obtained as to the background of early development and training. The child's parents died of influenza in the winter of 1918, and she became the ward of a children's organization. In the first boarding home she seems to have given no trouble, but in January, 1919, she was placed in a new boarding home. These people were kind to her, but apparently made little effort to understand her. Soon complaints arose that the patient was excitable, slept poorly, and had outbursts of temper. She was discovered taking a few cents when sent to the store on errands. To cover up the matter, she made false excuses, and when they were discovered, she had screaming spells. One morning the curls of another little girl in the family were found clipped off, and the scissors with which the deed had been done were located in the shoe of an older child in the household. When accused, the patient denied the act and was returned in disgrace and hardness of heart to the organization from which she had come. She was brought to the hospital for general examination. The physical status was normal. During the examination she maintained her innocence until the worker had withdrawn from the room, whereupon she told her side of the story. She hated the new boarding home and especially the little girl with the curls, to whom she was always being compared. The extraordinary behavior was merely a forcible way of registering this protest.

Suggested Modification and Results: The situation was explained to the worker, with the recommendation that the patient be tried in another boarding home, where her needs were understood. This plan has worked thus far with good results. The child seems to be adapting herself to the new environment without difficulty.

H. K. (No. 8) was eight years old when he was referred for examination in December, 1917. From teacher and home came reports of stealing, sex irregularities, attempts to start fires, and repeating the first grade in school. He had taken books from the teacher's desk, money from a neighbor's, a box of tools from a garage. He not only masturbated freely, but was accused of trying to have relations with little girls of his own age. On several occasions he had started fires—once under a motor truck and once in his room. He had been in court for stealing, and had received all sorts of punishment without improvement.

Examination of Patient and Situation: The patient's father is in the navy and is seldom home. His own mother died in 1915. Nothing of importance was learned as to his early development, but the complaints appeared strangely coincident with the arrival of the stepmother. Living conditions were above the average of dispensary patients. The patient's physical examination was normal, and he had an intelligence quotient of 100. He appeared frank, admitting all the things of which he was accused except the relations with girls, which he constantly denied. He denied any motive for his conduct, nor did he show tears or anger or seek to excuse himself. The father was inaccessible; the stepmother appeared honest until asked to carry out a practical suggestion.

Suggested Modification and Results: The family wished to have the boy sent to a disciplinary institution. It was suggested that he be tried out in a boarding home, with special supervision as to his requirements. The parents would not consent and refused coöperation in any other way. The patient disappeared from our view until some nine months ago, when he was brought in by a children's welfare worker with the same old complaints. A boarding home was found for him in a suburb of the city. In this home he was the only child, and the object of the wise and kindly supervision of two people who understand boys. The results at the end of six months seem to prove that the experiment was worth trying. To date there has been no recurrence of stealing, setting fires, or sex misdemeanors. The patient still masturbates at times, but with his opportunities for day-dreaming and fancies reduced by concrete activities and wholesome interests, this habit is much less marked.

Discussion: The stories of these children arouse thought concerning the sources of incorrigibility, which the psychiatrist, the probation officer, and the reformatory worker see in the early flower of adult life. What starts the individual energy into these circuitous channels? In J. D. one has a plain "get square" reaction; in H. K. an unmotivated push of activities and instincts readily diverted into normal behavior, even after they have existed long enough to fulfill the laws of habit formation.

Reflection in summary cannot but dwell on the elastic possibilities of the word "situation." In the cases cited above the term is associated with a wide range of facts connected with the start in life that these particular children have had. A glance at the column of situational data reveals handicaps of living conditions, poor habit training, and strains of parental attitude, the tracery of which one often sees in unsound adult reactions. The self-assertion and initiative of M. S., aged three, for example, expressed themselves quite differently from the same traits in H. K., yet both were in part the resultant of unfortunate forces at work in the background of their respective environments. Speculation as to the reason why one child of our group reacts to nagging and anxious fear with vague choreiform movements, while another becomes dull and apathetic, may take one far afield without discovering the combination of factors that started the abnormal behavior. Parents and teachers are concerned with the course of the behavior and how it can be modified. Should the twitching or speech trick be ignored, or should it be made the object of argument and reprimand? Ought shyness and lack of initiative to be handled by aggressive or suggestive tactics?

In answering these and many other questions that come up in individual case studies, the physician faces the issue of getting family and school to carry out the suggestions offered. As a matter of fact, this phase of the work is less of a problem than those who have not tried it suspect. For example, the mother is not asked to give her consent to a procedure of which she would be merely the spectator, such as an operation or some other form of manipulative therapy. Neither is she requested to be a party to dark and mysterious rites that appeal to her faith through imagination. Moreover, by the time she comes to the psychopathologist she has usually been disillusioned in regard to blood and worm medicines, and often has a spirit chastened by ineffectual attempts to handle a condition that is becoming progressively more baffling. In this frame of mind she is quite susceptible to a frank talk about the facts of the case as the physician sees them, even when these facts indicate a change of attitude and a course of procedure directly the opposite of that she has been following. Especially is her coöperation elicited if she is given specific suggestions as to habits of food, sleep, play, school work, the management of temper tantrums, sulkiness, etc. To illustrate, the mother of C. K. (No. 1) showed no resentment at the suggestion that her boy appeared retarded and different from others of his age because she had adopted an attitude toward him that often tends to foster such symptoms. She was willing to try out another plan which brought the child into contact with more children, gave him greater freedom in play, and created an opportunity for him to grow in self-management. Likewise, it is usually not difficult to get the school to contribute its share toward reconstruction of the situational background. Fifteen minutes' talk with a child's teacher will often do more to iron out the wrinkles of a bit of classroom friction than several pages of typewritten report, especially if the talk be given as a tentative suggestion rather than in the spirit of scientific dictum. It is the personal contacts with child and teacher and parents that count. In short, the physician's ultimate consideration must be with the "doings" in every instance, no matter how elaborate his analytical study of the "final essence."

CASES OF SEVENTEEN CHILDREN REFERRED TO

NOTE: In this chart B. stands for

Case	Sex	Age	Difficulty	Physical status
1 C. K.	B.	8	"Backward in everything."	Normal. B. S. 8 years plus.
2. A. G	B.	13	Twitching of eyelids and occasional stuttering. Vague somatic complaints.	Normal.
3. H. K.	G.	9	Stumbling and "general dumbness."	Normal. B. S. 8 years plus.
4. M. R.	G.	12	Stammers in school.	Normal.
5. B. C.	G.	13	Enuresis.	Gynecological condition negative.
6. E. F.	B.	7	"Stomach trouble and nervousness—chews clothes."	Slightly under-weight.
7. E. H.	B.	9	Occasional stammering Nervousness.	Somewhat under-nourished.
8. H. K.	B.	8	December, 1917. Stealing, backwardness, sex irregularities.	Normal. B. S. 8 years.

THE HENRY PHIPPS PSYCHIATRIC DISPENSARY

boy, G. for girl, B. S. for Binet-Simon.

Situational data	Suggested modifications	Follow-up notes—Feb., 1921
Parents separated. Anxious mother and grandmother. Poor habit training. Repressed at home.	Avoid over-solicitude and nagging. Encourage group play.	Mother reports patient full of initiative—leader in games on playground. Seems to have outgrown his "cowardice," timidity, and seclusiveness.
Bed at 11 p. m. Clings to mother. Little interest in play. Mother and teacher worry over the "nervousness."	Regular sleeping habits and more outdoor play. Nervous tricks should be ignored.	Slight residual of eye tic, but speech hesitancy not noted. No somatic complaints. Patient has taken up mechanical drawing with hopes of technical training later.
Patient has been ward of social agency four years. Various boarding homes with poor adaptation. Teased about shyness. Has no idea of play.	Foster mother advised to win patient's confidence by encouragement and patient inquiry into difficulties. Stumbling to be ignored.	Foster mother reports disappearance of stumbling. Marked initiative in play. Teacher notes improvement in school work.
Patient only child. Mother chronic worrier—constantly pushing patient—fearful of disease.	Mother shown that her ambitious anxiety embarrasses patient. Teacher to coöperate. Liberal program of diversions for mother and patient.	Teacher reports no further hesitancy in speech and patient more at ease in classroom.
Family move frequently. Detached schooling with feelings of discontent—too "old-fashioned" to play. No supervision in habits of living.	Regulation of habits. Attempt to create healthy satisfactions associated with school, neighborhood, and church.	Gradual declining in enuresis—no lapses for last six weeks; more interest in school work; joining Girl Scouts.
Poor habits of eating and sleeping. Temper tantrums since four years. Irritable, nagging mother—over-critical of patient.	General hygienic measures as to food and sleep. Mother warned against over-solicitude and worry about patient.	Mother easing up on watchfulness. Reports patient less "nervous" than he has been for years.
Poor food (candy and pickles). Tantrums if denied. Movies four times a week. Late bedtime. Sleeps with grandfather. Stammers when "crossed" at home or in school.	Regulation of food, sleeping arrangements, and movies. Mother given insight into "spoiled child" behavior. To ignore stammering.	Improved general appearance and behavior. Less excitable. Stammering has apparently disappeared.
Stepmother secretly hostile to patient. Father unaware. No attempt in home to discover motives for patient's behavior.	Readjustment of situation in home attempted without success for two years.	Child placed in boarding home under careful supervision. During past six months boarding mother has noticed no tendencies formerly ascribed to patient.

CASES OF SEVENTEEN CHILDREN REFERRED TO THE

NOTE: In this chart B. stands for

Case	Sex	Age	Difficulty	Physical status
9. S. A.	B.	5	Speech difficulty.	Normal.
10. M. S.	G.	3	Pains in her knees. Screaming at night.	Negative.
11. M. W.	G.	11	"Heart trouble."	Normal
12. J. D.	G.	7	Lying, stealing, incorrigibility.	Normal.
13. H. P.	G.	7	"Loss of memory following flu," March, 1920.	Normal. B. S. 6 years plus.
14. R. A.	G.	11	Excitability and enuresis.	Normal. B. S. 10 years.
15. A. G.	G.	6	"Convulsions."	Normal.

HENRY PHIPPS PSYCHIATRIC DISPENSARY—*Continued*

boy, G. for girl, B. S. for Binet-Simon.

Situational data	Suggested modifications	Follow-up notes—Feb., 1921
No attention at home. Shy—does not play well. Teased and nagged about speech.	Kindergarten. Parents told to encourage, not criticize. Regulate living habits.	Patient gradually thawing in school. Talking slightly improved.
Patient sensitive and very imitative. Father's pet till birth of brother 15 months previous. Sleeps in room with parents. Father being treated for arthritis of knees.	Child to sleep in room by herself. Probable mechanism of complaints explained to parents. Apparent somatic distress to be ignored.	Mother reports patient free from pains for two months. Sleeps quietly.
Symptoms began three years previous with death of father and mother's remarriage. Attacks of "collapse" diagnosed heart trouble by doctor. Patient becomes invalid. Taken from school. Three pillows at night.	Mother reassured following Johns Hopkins Hospital examination. Patient to go to school and take up normal interests in play.	Patient in school since November 1, 1920. Good progress. No recurrence of attacks.
Parents died in 1918. Patient ward of children's agency. Unfortunate boarding homes with antagonistic reaction by patient.	Attempt to find boarding home where patient will be understood.	Child reacted to new environment with more coöperation. No recurrence of previous complaints.
No abnormal behavior or nervous tricks. Patient spoiled by mother since flu. Great alarm over petty complaints. Patient tells teacher she is nervous. Kept out of school.	Return to school. Mother urged to worry less over patient.	Teacher reports some improvement in school work, though mother is still too solicitous.
Four cups of coffee daily. Late bedtime. Constant nagging by stepmother. Father irresolute.	Regulation of living habits. Attempt to show stepmother ill effects of her critical attitude. If unsuccessful, try patient in boarding home.	Enuresis only occasional. Patient quieter in demeanor. Noticeable progress in school. Stepmother pleased with improvement.
No loss of consciousness, but attacks of wriggling and sliding to ground coincident with change from mother's bed to sleeping alone. Parents ignorant and superstitious. Much therapy for "worries" and epilepsy.	Return to school. Parents urged to ignore attacks. Teacher to coöperate.	Marked improvement. Occasional attack in relation to temper tantrums. None observed in school.

CASES OF SEVENTEEN CHILDREN REFERRED TO THE

NOTE: In this chart B. stands for

Case	Sex	Age	Difficulty	Physical status
16. M. S.	B.	8	Twisting mouth and twitching shoulders.	Normal.
17. D. S.	G.	2½	Retardation in speech. Screaming.	Normal.

HENRY PHIPPS PSYCHIATRIC DISPENSARY—*Concluded*

boy, G. for girl, B. S. for Binet-Simon.

Situational data	Suggested modifications	Follow-up notes—Feb., 1921
Mother nagging and over-solicitous. Patient envious of older brother boarded in country. Patient in third grade. Hebrew lessons daily, 3:30 to 6 p. m.	Substitute play for Hebrew school in p. m. Mother warned against pushing patient.	Mother reports discontinuance of tricks under new régime.
Only child in family of grown-ups with grandparents on both sides living. Not allowed to play with other children. Continuously waited on and spoiled.	Give patient incentive for talking. Less attention. To play with other children.	No further screaming sprees. Some improvement in talking. Mother skeptical and anxious—fears contact with other children.

MENTAL HYGIENE IN INDUSTRY*

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MENTAL hygiene is the natural supplement to physical hygiene. In promoting the physical health of the individual, our interest depends upon the implicit belief that human life has a value, that the individual cannot carry out his social duties in the best way without physical health. Physical hygiene does not concern itself with these special social duties, but confines itself to seeing that the simple machinery of the individual is attended to, is repaired after damage, is kept in good order and not subjected to undue stress and strain. It is poor economy to wait until the machine breaks down and then try to patch it up. It is better to keep it in good working order and to see that it is not used for unsuitable purposes. From this point of view, emphasis is laid not so much on the treatment of individual cases of disease, but on taking the necessary social measures to prevent the occurrence of disease. In order to carry out these measures, the physician must have the coöperation of the community, and this coöperation will depend upon the community's intelligence and its feeling of social responsibility. For this coöperation, it is necessary that the community should get information with regard to sickness, and that the individual should feel some interest in promoting the public health and not merely in safeguarding his own home.

In relation to such matters as typhoid fever and smallpox, it is not difficult to put the simple facts clearly before those who are not familiar with medical matters and to persuade them of the practical advantages of a pure water supply and of general vaccination. Sometimes an epidemic is required to drive home the situation, to make men pay increased taxes for a water supply or accept such useful measures as vaccination, which may happen to be disagreeable to them on various personal grounds.

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* Read at the Annual Conference of the Massachusetts Society for Mental Hygiene on the Human Element in Industry, April 7, 1921. Other papers in this symposium were *Has Mental Hygiene a Practical Use in Industry?* by Boyd Fisher (see page 479), and *Industrial Hygiene*, by Dr. Wade Wright (see page 497).

The extent to which this conception of preventive medicine has developed is indicated by the fact that practical steps are now being taken, not only against such scourges as infectious diseases, but in relation to many other causes of ill health, and an organized effort is being made to eliminate the preventable causes of ill health in special industries. This movement would hardly be possible were it not that, in relation to the more dramatic facts of infectious diseases, the public had realized their responsibility for preventing what can be prevented and were thus educated in the idea of prevention to such an extent that they realized the advisability of going further and applying their health conscience to the industrial environment. This public conscience, this responsiveness of the community to the facts of disease even when they do not touch one personally, is the greatest encouragement to those who are dealing with the field of mental hygiene, where the situation is more complicated than is the case with infectious disorders, and where there has not been such a long history of intensive study. It is not so long since mental disorder was considered less a disease than a disgrace or a crime. Even now, in some places, the mentally sick person is brought into court on a "charge" of insanity, and a jury of laymen pass on the situation.

The treatment of these disorders has made considerable progress. The study of them now proceeds along the same lines of intensive research as the study of other disorders. We have reached the stage when we feel it our duty to see what can be done in the way of prevention. It may be felt by some that the problem is too difficult, the facts too uncertain, the situation too complex for any one cause to be made responsible, and that the remedies are not sufficiently definite for the public to be asked for coöperation in relation to these troubles. Some of the facts, however, are very definite, and the community should know these facts, even where there is no simple remedy to be proposed. The community at large should realize what influences in general are of importance, in order that changes, where practicable, be made, and in order that the general attitude of the public toward these problems should be as enlightened as possible. It is with this end in view that a national committee and a group of state societies interested in mental hygiene have been organized.

In discussing the general topic of hygiene with non-medical people, it is not necessary to give elaborate explanations. One can refer to typhoid fever and to smallpox, to lead poisoning and other industrial disorders, and assume some familiarity. It is somewhat different when one is dealing with mental disorders, for there is still widely prevalent a rather medieval attitude toward mental disorders, which are considered to be absolutely different from ordinary forms of sickness.

Mental hygiene is not concerned merely with those serious forms of mental disorder which require treatment in state hospitals; it is concerned with those other forms of mental disorders which do not necessarily mean the removal of the individual from his ordinary social environment. A disorder is a mental disorder if its roots are mental. A headache indicates a mental disorder if it comes because one is dodging something disagreeable. A pain in the back is a mental disorder if its persistence is due to discouragement and a feeling of uncertainty and a desire to have sick benefit, rather than to put one's back into one's work. Sleeplessness is a mental disorder if its basis lies in personal worries and emotional tangles. Many mental reactions are indications of poor mental health, although they are not usually classified as mental disorders. Discontent with one's environment may be a mental disorder, if its cause lie, not in some external situation, but in personal failure to deal with one's emotional problems. Suspicion, distrust, misinterpretation, are mental disorders when they are the disguised expression of repressed longings, into which the patient has no clear insight. Stealing sometimes indicates a mental disorder, the odd expression of underlying conflicts in the patient's nature. The feeling of fatigue sometimes represents, not overwork, but discouragement, inability to meet situations, lack of interest in the opportunities available. Unsociability, marital incompatibility, alcoholism, an aggressive and embittered social attitude, may all indicate a disorder of the mental balance, which may be open to modification. Acute phenomena characterized by unreasoning emotional reactions, such as lynching and other mob reactions, waves of popular suspicion sweeping over a country, may be looked upon as transitory disorders. The same factors that are involved in these familiar reactions play an important part in the development of insanity.

The immediate problem of the physician is to discover the causes of, and the treatment for, these disorders. His social responsibility imposes on him the problem of seeing how far these conditions can be prevented, either by widely diffusing medical knowledge, so that the individual may safeguard himself, or by helping to organize social conditions, so that the individual gets a fair chance of developing a healthy mental balance and so that he is not exposed to undue stress and strain. The most important piece of social apparatus for the prevention of mental disorders is the school system, under whose moulding influence every one remains for a period of many years. In the adult period there seems no more promising opportunity for influencing a large body of the population than that provided in the various industrial units. Although these are organized for production and profit, and the keynote is output and efficiency, the latter need not be incompatible with an interest in health and happiness. From one point of view, the worker is a machine, but this does not need to dehumanize the worker; the industrial organization may recognize that it is important to pay attention to the most valuable and delicate part of the human machine, to that part which makes the man of more than economic value, makes him a spiritual asset to his community. Even from the point of view of output and efficiency, it has been found important to pay attention to the condition of the worker, to the general physical environment, to the elimination of trade irritants, to the opportunity for early attention to minor ailments and injuries. It has also been found economical to study the conditions that determine fatigue, the advantages of rest periods, the suitability of different types of men for different jobs. The keynote of all that work has been essentially efficiency; the interest has been in what the man meant for the work, and not what the work meant for the man. It is the latter question that has become the most important problem in the industrial world at the present time. It is not because of lack of intelligence or defect of skill that the worker develops the symptoms referred to above. It is often in relation to the poor amount of satisfaction he gets out of life. It is in relation to the balance of his instinctive cravings and of his emotional reactions; it often depends on an unsatisfactory relationship to his fellows, his employers, his family.

To illustrate these rather general remarks, one may take a concrete situation. Chronic alcoholism has been a distressing personal and social symptom. The treatment has been prohibition. The question of why the individual reached out for this chemical stimulant has been a matter of secondary interest. Was it a morbid craving, a manifestation of original sin; or was it a habit casually acquired, but difficult to break; or was it one way of getting cheaply a sort of satisfaction that none of the ordinary opportunities of life offered him? Did the alcohol dull vague feelings of depression and discontent, and perhaps in addition supply a glorious feeling of satisfaction and raise him into a different world from the humdrum atmosphere of the factory and the depressing atmosphere of the crowded home, with the careworn housewife and the noisy children? The alcohol satisfied some cravings apparently, only temporarily, it is true, and in the long run at a great price, the price of deterioration of character; but the cravings of the individual, the longings for some sort of exhilaration and freedom from care, were perhaps fundamental human traits that found little means of honest satisfaction in other directions. Did the chronic alcoholic live in a community that offered him decent opportunities for satis faction along healthy lines, and had he been trained during his developing years to be able to utilize these sources of satisfaction? If the community offered few worthy opportunities for pleasure and recreation, then the chronic alcoholism could be looked upon as symptomatic of a faulty community organization. It is, of course, comforting for the community to be able to lay the blame on the alcoholic, and to be blind to the fact that we are partly responsible for the organization of the community. But it is surely not enough to punish the alcoholic or segregate him or banish his liquor; the fundamental problem is not dealt with until we know the condition of which the alcoholism is merely a symptom. For the purposes of prohibition, of removing opportunities for alcoholic satisfaction, an army of officials must be employed, with an elaborate organization and skilled direction. If one looks for a comparable expenditure of money and thought directed toward supplying other sources of satisfaction to the ex-alcoholic, one is rather disappointed. Many persons who are seriously offended by the sight of drunken men on the streets are absolutely insensitive to the fact that alcoholism may have deep-seated social causes, with regard to which they have a certain personal responsibility.

In many of these cases of chronic alcoholism, we might find it worth while to study the conditions of the man's life, and to see what opportunities there were for a healthy outlet of his natural cravings. What are the satisfactions that a man craves? He enjoys the simple pleasures of the satisfaction of the appetites, pleasure in work, pleasure in family life, pleasure in games and other recreations, and pleasure in social intercourse; he enjoys a feeling of self-respect, that comfortable feeling that life is worth living and that what one is doing is worth while, whether it be as wheel greaser or locomotive engineer.

As to the possibility of getting pleasure out of one's work, conditions vary extremely. The average professional man is engaged in work that was deliberately chosen, that appeals to him and corresponds to his native disposition. He gets joy from it, although in every kind of work there are periods of hard drudgery. Such periods are, however, rendered tolerable by the knowledge that they are essential to a successful career; the knowledge of the rewards—academic, social, or financial—that the labor may bring carries one through the periods of drudgery. But joy in work, which belongs to the skilled craftsman or the professional worker, is a luxury that many other workers do not have. Many a worker has to content himself with work not deliberately chosen, but thrust upon him by constraint of the social environment. The nature of the work may be such that there is little possibility in it of giving satisfaction to any one with average aspirations.

In the modern industrial system, large numbers of men are thus engaged during a large part of their working hours, working merely that they may live, getting no special pleasure from the work, looking for satisfaction to the period of the day when they are released from their drudgery. The possibility of satisfaction after work depends, first, upon absence of excessive fatigue; secondly, upon certain economic conditions; thirdly, upon decent opportunities in the environment for recreation; fourthly, upon having had the training that enables one to utilize the means of satisfaction available in the environment. There may be wonderful libraries, picture galleries, and symphony concerts close at hand, but unless the individual has been trained to utilize such opportunities, they are practically nonexistent. One simplest source of easy satisfaction was the saloon, where the worker could quickly get a transitory feeling of well-being. The leisure of many is spent in perusal of the newspapers, and there they get a vicarious satisfaction in reading of divorces among the rich, of daring crimes, and highly emotional presentations of racial, religious, and national issues. The presentation of social life that is found in the newspapers can hardly be said to be a well-balanced presentation of the main issues of the times. If not inclined for reading, the worker may go to the moving pictures, where he sees a still more lurid presentation of human life, and where he can, for a while, revel in the imagination of living in palatial surroundings, indulging in doubtful practices, and having a highly romantic and thrilling time. In summer he may get additional emotional excitement from being a spectator at a popular ball game.

Man is wonderfully adaptable, and many men cheerfully continue in toilsome, dangerous, monotonous occupations, creatures of habit, doing as their fathers have done; but it is important to remember that in these routine workers there are the same fundamental cravings, latent and liable to express themselves some day in a rather disconcerting form. Others may feel the monotony of their task, but get some interest from the relationship of their work to the total work of the plant, or from association with their fellows, or perhaps from some personal attachment to an employer. Others do not get their satisfaction from these objective sources, but, while working at monotonous tasks, live in a world of their own imagination, day-dreaming of romance and riches. In others it is the religious attitude toward life that makes the situation tolerable. The lack of satisfaction seems unimportant and the discouragements of this life seem trivial in the light of the fuller life that is promised by religion, which reconciles the worker to social inequalities and enables him, under hard economic and social conditions, to continue cheerfully productive.

Some get a touch of romance and glory by joining social organizations in which they are nominated to posts with high-sounding names. Others have no such compensations, but drift along in a rather dull, sodden way, until they, too, find a source of some satisfaction; their minor ailments begin to engross their attention, they frequent the dispensaries, and a long period of intermittent invalidism may ensue. After all, to be an invalid has its gain; our misery entitles us to some respect—it may even entitle us to some compensation.

Other workers, of different temperament and tradition, react to their working conditions in a way that has still greater social importance. They, too, indulge in stimulants, but there are other stimulants than alcohol; one may be intoxicated with words as well as with wine. The stimulus of cheap oratory, of fiery propaganda, of dazzling promises, of idealist conceptions, may make the head swim, the pulse beat quicker, the eyes see red; there are certain highly intoxicating social doctrines, which hold out hopes of a new order, in which the promises of religion are to be partly realized in this world. Enthusiasm for these theories leads to the opposite of the resignation that may go with religious belief. The new order is to be realized as soon as possible; persons, institutions, beliefs that stand in the way arouse keen resentment and, each man's hopes and hates being reinforced by those of his fellows, a powerful force develops, which is the cause of much social rumbling. These dazzling theories take little account of realities, of biological facts, of economic laws, of historical development; men whose latent cravings have had little outlet for many years, whose pent-up emotions have made it difficult to observe accurately and to judge impartially, are easily intoxicated with economic, social, and political theories that correspond to their wishes, and develop a habit of wishful thinking, which is perhaps more serious than a drug habit.

Here, again, we may try prohibition, may close the saloons of oratory, make it a penal offence to offer others a draft of intoxicating promises and theories; but the question again arises, will we do more than merely close another outlet for the underlying cravings of human nature? The subject of mental hygiene in industry is too wide to be covered in a short address; the above remarks merely illustrate an aspect of the problem that is too much neglected, and deal with industry from the point of view of what the work means to the man. From the point of view of what the man means to the work, there are many interesting problems that are attracting attention; the question of fatigue, the problem of placing those who are constitutionally unstable or poorly endowed, of utilizing those who have already had a breakdown, of offering good facilities for the early treatment and care of mental and nervous disorders, the best methods for studying intensively the special abilities and disabilities of the individual, are topics on which much has been written and much work remains to be done. But the aspect of the problem that has been discussed is the one that has the greatest social importance, the one most closely connected with the question of social stability.

We all crave quick and sure remedies for our troubles; the great sales of patent medicines bear witness to this craving. So, with the maladies of the body politic, we wish a definite diagnosis and a specific remedy. Matters, however, are not so simple. The mother brings her child for examination on account of a single symptom, but to understand the symptom one may need to study the whole child; one may even have to study the parents and the home atmosphere and, instead of giving the mother the desired bottle, one may have to explain to her the relation of the symptom to a complicated social situation. Whether or not she will utilize this explanation will depend upon many factors.

A school system that takes stock of the minor ailments and nervous disorders of the children, and follows the children from the school clinic into the home by means of nurses or visiting teachers, can exercise a remarkable influence on the mental hygiene of these homes. For the adult, the only analogous situation would be that in which the industrial clinic, aware of the importance of mental factors, developed its social work in the same way. To understand the symptoms of the industrial worker, it may be necessary to consider, not only the usual facts dealt with in industrial hygiene, but also the amount of satisfaction got out of work, the atmosphere of the home, the opportunities supplied by the general social environment for healthy social intercourse and for intellectual and æsthetic enjoyment. The industrial clinic, if interested in mental hygiene, might exercise a social influence comparable to that of the school. Unfortunately the worker is on the defensive, suspects exploitation, resents interference; some day perhaps the industrial workers themselves will take the lead in encouraging the study of the conditions of mental health in the industrial worker and in constructive suggestions as to social arrangements.

Summary

The mental health of the industrial worker depends upon the complicated interplay of the individual personality, the specific conditions of the industrial task, the economic factor, the domestic and general social environment.

When dealing with the disorders of the individual worker and of groups of workers, it is not always possible to isolate single symptoms and supply specific remedies, medical or social; and one must be prepared to make a very detailed analysis, and the remedies may be of slow evolution.

So far there is not available enough well studied material for useful constructive suggestions to be made; to gather such material is a task of immediate importance.

The development of an enlightened public opinion on these topics would be a most important contribution to the mental health of the community and to social and economic stability.

The attention paid during war time to the mental health and morale of those engaged in the business of destruction is no less necessary during peace time for purposes of construction; mental health and good morale are as important in peace as in war, and to muddle along in peace may be as disastrous as to do so in war.

HAS MENTAL HYGIENE A PRACTICAL USE IN INDUSTRY?*

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THE president of a company operating a group of industrial plants has become acquainted with rather startling facts put forward by those who have been specially interested in studying defective children, and who have extended their special psychological tests to the study of mental defects in adults. The figures given by these authorities seem to conflict with common sense. He has seen the assertion that one million, seven hundred thousand drafted men were given psychological tests during the war. Seventy per cent of these proved to have reached an intelligence age of no more than fourteen years. Forty-five per cent of the total number were "morons"—that is, of so low intellectual capacity as not to be capable of complete self-guidance.

Our president also has read the review of a book called *Human Efficiency and Levels of Intelligence,* by H. H. Goddard, and notes that the author, working on the assumption that the army was a fair cross section and a large enough sample of our population, has applied the army results to our whole people. Goddard asserts that seventy million Americans are no more than fourteen years old in intelligence. He further considers the facts in relation to industry and makes the point that the inefficiency of large numbers of workers is probably due to their being assigned to tasks that they can never learn to perform well.

In addition, Goddard seeks to substantiate by figures his contention that the low intelligence found in the army is seen also in the general population, as evidenced by the number who "finish school" at an early age, and, in industry, as evidenced by earning power. Thus, in the accompanying table,[1] which shows the earnings of groups of wage earners, and compares the age at which various groups leave school with the mental ages of the various groups of soldiers, we see that 68 per cent of wage earners make less than fifteen dollars a week, and 67 per cent of school children do not finish the eighth grade, or grammar school, which corresponds to the 70 per cent of soldiers who are below fifteen years in mental age.

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* Read at the Annual Conference of the Massachusetts Society for Mental Hygiene on the Human Element in Industry, April 7, 1921. Other papers in this symposium were *Mental Hygiene in Industry,* by Dr. C. Macfie Campbell (see page 468) and *Industrial Hygiene,* by Dr. Wade Wright (see page 497).

WAGES

Of 100 wage earners

9%	earn	$150 — $200	per year
12 "	earn	250 — 300	per year
16 "	earn	350 — 400	per year
31 "	earn	450 — 600	per year
27 "	earn	750 — 1,000	per year
3 "	earn	$1,200	per year
2 "	earn	over $1,250	per year

SCHOOL

Of 100 children

13%	leave in	4th	grade, age	10
13 "	leave in	5th	grade, age	11
14 "	leave in	6th	grade, age	12
27 "	leave in	7th and 8th	grade, age	13, 14
23 "	leave	after 8th	grade	
10 "		attend high school		
1.5%		graduate from high school		
3 "		attend college		

INTELLIGENCE

Of 1,700,000 soldiers

10 %	in "D—"	Group, mental age 10	Morons able to contribute to support
15 "	in "D"	Group, mental age 11	
20 "	in "C—"	Group, mental age 12	
25 "	in "C"	Group, mental age 13, 14	
16.5 "	in "C+"	Group, mental age 15	
9 "	in "B"	Group, mental age 16, 17	
4.5 "	in "A"	Group, mental age 18, 19	

Let us suppose that one more thought has come to the attention of our president. He has heard Carleton Parker quoted as saying, "Modern labor unrest has a basis more psychopathological than psychological, and it seems accurate to describe modern industry as mentally unsanitary." He may even have heard that the late Dr. E. E. Southard, while head of the Boston Psychopathic Hospital, expressed the opinion that strikes and other forms of labor unrest may be stirred up by leaders of abnormal mental make-up, agitating among workers whose emotions are sick or whose intelligence is feeble, and that the cure for industrial discord lies as much in the field of mental hygiene as in the field of economics.

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[1] After Goddard. See *Human Efficiency and Levels of Intelligence.* Princeton: Princeton University Press, 1920. p. 114.

Our president is a canny soul. He suspects the accent of propaganda in such large generalizations. He realizes that even scientists will overstate the probabilities of results in a new field before they have become completely familiar with it and its special conditions. He ridicules the Southard theory by saying that if it be true, then all he will have to do to settle the labor problem is to hire a few doctors from the state hospitals for mental disease and make foremen of them. And yet can he be blamed for thinking that some such absurd inference is to be drawn from the generalization referred to?

Let us assume, however, that our president overcomes his first suspicion of all propaganda and decides to make some cautious inquiries. He may feel that nuggets of valuable truth are to be found even in extreme statements. He therefore asks his personnel or service adviser to look into the question and report at the end of a week. "I'd like to know," he says, "just what there is in all this stuff about mental hygiene."

It is from the naïve point of view of such an inquiry that the present paper is written. The writer is not a psychologist or a physician. He is just an employment manager, interviewing the psychiatrist who states that he, from his studies of human nature, can contribute some facts of interest to the employer. He treats this psychiatrist as he would a man applying for a job in industry. This paper does not reveal the results of any original research or indulge in any new inferences for the sake of propaganda. It is rather the sort of critical examination that must precede and accompany both research and propaganda. Furthermore, the paper has to be so brief that the process of development of all the ideas cannot be traced, but only the final steps are given.

At the start it seems necessary to give a few definitions. The layman is likely to confuse similar terms of quite dissimilar meaning—for instance, psychology and psychiatry, which he hears mentioned as different methods of examination into mental conditions.

Psychology is an offshoot of philosophy. In theory, it recognizes that the emotions and temperament have as important a place in personality as intelligence. In practice, whether in the army or in industry, it deals only with intelligence and skill. It is concerned with capacity, and arrives at its conclusions on the basis either of laboratory examinations with strange bits of apparatus or of classroom tests with written answers to standard questions.

Psychiatry is a medical science. It may utilize the results obtained by the psychologist as the basis for determining intelligence levels, but it is much more interested in the emotional and temperamental factors in mental states. It prefers to judge people by their actions in their usual environment, rather than by their reactions to a test. It, therefore, studies their workmanship, their home conditions, and their educational and job history. If their actions and accomplishments are normal, it leaves them alone; if abnormal, it wants a physical as well as a mental examination. What I believe that I am dealing with is psychiatry, largely, and to some extent psychology.

As for what is discovered by mental inquiry, there needs to be a clearer distinction in the public mind between feeblemindedness and mental disease. Physicians may be surprised to be told that intelligent laymen often confuse the two things. It seems necessary, therefore, to point out that feeblemindedness is a limitation of mental ability, either inherited or acquired at an early age. Although feeblemindedness may be accompanied by or caused by mental disease, a feebleminded person is usually sane and dependable in affairs that make no call upon thinking beyond his intelligence. Mental disease, on the other hand, may afflict people of brilliant capacity and may be physical (involving brain decay or nervous troubles) or merely psychological (involving disordered ideas and emotions). Especially it should be pointed out that neither feeblemindedness nor mental disease is an absolute, but is always a relative term. One person has more brains than another, and one person has more judgment than another. The psychiatrist is interested in mental inefficiencies or psychopathic states which are no more serious or uncommon in the mental sphere than colds and headaches are in the physical. Only, he recognizes that these mild troubles which afflict each and every one of us make us more unpopular or unhappy than physical ills.

It may be well at this stage to make clear what is meant by the term "mental hygiene" which will be used throughout this article. Mental hygiene embraces our knowledge of the laws of mental health, of the personal and environmental conditions that interfere with mental health, and of those mental habits and social influences which promote the mental health of the community.

It is important to emphasize the distinction between the modern medical and the purely spiritual approach to the problem of mental health. Too long did the medical profession insist upon treating the human mind as merely a brain, and refuse to consider any condition of mind not involving physiological change. The medical profession itself has been largely responsible for the vicious misconceptions clustering around the term "insanity." That term marks chiefly a legal distinction between people who are and people who are not responsible for crime. It is supposed to segregate "nuts" from all the rest of us. Those of us who are not "nuts" are assumed to be mentally sound. Legally, we are either sane or insane, just as we are either male or female. I need not stop to point out the many ways in which a new conception of relative mental capacities has been creeping into our criminology—particularly in the handling of juvenile delinquency, in the extension of the idea of the indeterminate sentence, and in such measures as vocational training in prisons. The public confusion on the subject of the insanity defense in murder trials indicates a weakening of the old distinction between sane and insane in law. Nevertheless, there it stands, a false conception, largely unshaken, and a legacy of the old corporeal medicine. The neglect of the mind by those in the best position to study its relation to the brain gave full liberty of action to those whose type of training compelled them to leave the brain out of their thories. Thus, the Christian Scientists and the Emanuelists have approached mental health from the spiritual side almost wholly, and have given a big start to the study of mental hygiene from the subjective and somewhat introspective angle. Modern medicine, however, has at last waked up and demanded a share in the field that it might have preëmpted. The modern medical approach to mental health no longer leaves the spiritual and subconscious aspects of the mind out of account, and even consents to use the results achieved by the spiritual workers. But it also insists upon relating the brain and the body and the physical environment to the problem. Furthermore, while it does not condemn the method of the psychological workers, it prefers, whenever possible, to continue in the method which it has found useful in diagnosing and treating diseases of the body. If subjective tests yield anything of interest, it wishes to confirm these findings by objective study of symptoms and behavior, under observation within predetermined conditions. This medical approach is the method of psychiatry; and when I consider the problem of the place of mental hygiene in industry, it is precisely this method I have in mind. It is the only method that resembles the manner of meeting and overcoming problems in industry. We do not look for improvements in industry chiefly to those who examine only their own minds and desires for theories of change. By the same token, we should not look for true mental science to those who do not relate the mind to its determining environment.

Having narrowed our inquiry by definition to a question as to the place in industry of the medical approach to mental hygiene, let us next see what a genuine practitioner in this field would like to do, if he had his way with industry. Dr. Stanley Cobb, who teaches the subject at the Harvard Medical School, has written a paper entitled, *Applications of Psychiatry to Industrial Hygiene,*[1] in which he has stated the aim of psychiatry in a way that all psychiatrists would probably be willing to accept. "As conditions are at present," he says, "a reasonable application of psychiatry to industry would seem to be the following:

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[1] See *The Journal of Industrial Hygiene.* Vol. I, pp. 343-47, November, 1919.

"1. Physical examination of all applicants for work.
"2. Mental examination by (a) a period of training and observation, or (b) through mental tests.
"3. Keeping in personal touch with employees' individual problems by means of (a) good foremen, (b) a system for watching individual efficiency, or (c) a sympathetic staff with a psychiatric point of view in the employment-management office, thus salvaging the men who might otherwise be fired.
"4. Training the industrial physician to a knowledge of how human nature is constituted, not in conventional terms, but in the light of a dynamic and living psychology."

Even from the point of view of one wholly unfamiliar with the subject, Dr. Cobb's program does not sound extreme, and it has some inherently attractive features. Nevertheless, it would involve a degree of attention to mental problems which industry is not now giving, and it would assume that the industrial physician had, during his medical curriculum, got some insight into the fundamental factors involved in mental disorder and defect, or it would necessitate the industrial physician's spending a brief period in study in connection with some psychiatric clinic, in order to perform his work more adequately.

Now we are supposed to be asking ourselves just how far industry would consider these things to be practical. But perhaps it would be well first to ask if there are any obstacles to our doing them, even if they were practical. We know that there are many things that we could do and perhaps ought to be doing, but that, because of some obstacle, we are not doing. The religious issue, for instance, is an obstacle in the way of a practical solution of the Irish question. Opinions about President Wilson created an obstacle to the practical solution of the peace question. I think that there are obstacles to the early adoption of psychiatry in industry.

First of all, physicians, as at present trained, have an extremely meager knowledge of psychiatry, and unless they have spent some time after graduation in specializing in this branch of medicine, they are not in a position to deal adequately with the problem of mental hygiene in industry. It is, therefore, certain that at the present moment there is no adequate medical personnel with psychiatric training to place at the disposal of large industrial organizations, should they desire such coöperation. The universities have become aware of this deficiency and are doing what they can to improve the situation, but progress in medical education is necessarily slow, and it will be many years before industry can expect to find among the medical profession the necessary number of physicians competent to deal with these problems.

A well-known employment manager of my acquaintance writes me that she considered last year engaging a psychiatrist, but was scared off because those she interviewed wished to subject all employees to a mental third degree. She felt that, what with physical examinations and centralized discipline, the workers were submitting to just about enough already.

Another factor to keep in mind is the necessity of extremely tactful introduction into the industrial relations of any type of examination that seems to be too intrusive or to suggest personal disqualifications, with regard to which an individual is apt to be extremely sensitive. In this connection, tact is of supreme importance. Any one will chatter, if not boast, about his symptoms of Bright's disease; and if, perchance, he has been operated upon—had his stomach removed and his duodenum sewed on to the esophagus—he takes a childish delight in talking about it. But where is the man who will admit that he is not as bright as he might be? No one likes to discuss his mental failings, precisely because of the common impression I have before mentioned—that a man is either sane or insane. This brings it about that any inquiry into a man's degree of mental efficiency is construed as a doubt of his sanity. But that is not the whole source of the difficulty. The special sensitiveness about mental diagnosis is due also to the fact that our minds are so much more *us* than our bodies. Those who believe in personal immortality dispute as to whether the body will be resurrected, but none doubt that the mind is immortal. To suffer loss in a member of the body is no more serious than forgetting a part of our past experience; but touch the vital core of all our life—our sound and self-disposing mind itself—and you do us more serious injury than in paralyzing our whole body.

Perhaps a third difficulty consists in the fact that emphasis on the conditions of mental health tends to suggest a new philosophy of life, a new attitude towards social discipline and control.

If it is true that people vary in mental capacity and mental health, and that each different degree of capacity involves a different degree of power, of judgment, and of corrective behavior, then it is also true that people vary in degree of moral accountability. The old definition of sanity was "ability to distinguish right from wrong." Those who were sane were held accountable for their acts and punished when they did wrong. The psychiatrist points out, however, that perception of moral and ethical questions varies according to the individual, and that waiting for wrong to be committed and then punishing it is wasteful and ineffectual. He proposes, instead, an adjustment of society and industry in which a man's competence to act will be tested, and his freedom of choice restricted to those fields in which he is capable of acting correctly.

Now this, if carried out to its logical conclusion, would involve a very saddening restriction of the freedom of the will and of liberty of action. The old theory of strict accountability was so much more tonic. It was too bad to see any one go to hell because he willfully lacked judgment, but it was a great game to be free to go wrong at any time. It was thrilling to fight the great fight twixt Good and Evil every day. Even if you didn't know which side you were fighting on, it was a great fight anyway.

I feel very sure that people who resist prohibition, people who oppose sterilization of criminals and feebleminded, people who set up a particular theological formula as a guide to all right conduct, will resist the theory of limited accountability. It is not merely a misconception they will have to get over, but their whole philosophy of life.

Perhaps I dwell too long upon obstacles. But part of the discussion can be credited to consideration of how to overcome them. In the psychiatrists' method, if I understand it, a complete examination of erroneous ideas is part of their cure. To recognize prejudice as prejudice is to go a long way toward dispelling it.

The obstacles can be overcome sufficiently for psychiatry to make its way. Truth can advance through and around error. We can have gradual immunization against smallpox even in a state where the legislature surrenders the public right to protection by vaccination, and these difficulties in the way of psychiatry will probably all be met. In the first place, the psychiatrists will be less queer when it seems less queer to be a psychiatrist. The present group constitute a kind of volunteer poison squad who taste the new doctrines as an encouragement to the more conservative. Again, a tactful education of the public on the subject of relative mental conditions will make study of mental efficiency seem less awful. And the way to make the extension of psychiatry to the great mass of ordinary people seem less of an insult is, precisely, to extend it. Until these obstacles are overcome, however, I do not look for a very widespread and public use of psychiatry in industry.

Must psychiatry wait, then? We shall all be dead before prejudice dies. Fortunately for progress, a novelty does not have to wait until it can be widespread and self-asserting before it can get a foothold. Novelties have to make a piecemeal conquest. Samuel McChord Crothers, in an illuminating essay entitled, *Protective Coloring in Education,* has pointed out how every new truth has come in under the cloak and favor of an older and more acceptable doctrine. When theology was master of logic, science had to present itself as an interpretation of the gospels. Hugh Miller's original book on geology purported to be an explanation of the first chapters of Genesis. Paley's studies of anatomy and physiology were offered under the title of *Natural Theology.* At another time, when polite literature was the more respectable, Charles Darwin's grandfather published a treatise on botany in the form of an allegorical poem, entitled, *The Loves of the Plants,* in which the real information was conveyed chiefly in the footnotes.

I am inclined to think that a subject which has to meet so much ignorant prejudice as psychiatry will also have to adopt some protective coloring. I think I can point out, indeed, that some phases of the subject are already developing in industry without any one's suspecting it.

In the first place, consider the gradual adoption of the idea that there is such a thing as a varying degree of intelligence or mental capacity. Recently, in the clothing trade in Baltimore, the unions themselves agreed to a grading of workers according to ability, A, B, and C, and consented to varying rates of compensation in each grade. Management has long contended that there are differences between workers, not only of temperaments and bents, but also of capacity in general. For this reason, partly, it has rejected the idea of a straight day wage, and insisted upon payment according to output. Lately it has gone further and begun to rate workers according to intelligence and other qualities as a basis for assignment and promotion. Armour & Company, the Westinghouse Companies, the General Electric Company, and Sears Roebuck are among the well-known concerns doing this. It is true that such ratings are made upon the basis of the uninstructed opinions of superiors, and not on a psychiatric or other presumably scientific basis, but the idea of relative mental capacity is certainly implied in the proceeding.

Correlative to such rating schemes has been a corresponding development of the idea of "job specifications." Nearly every modern employment department has made, or is making, a set of job specifications. These are standard descriptions of mechanical operations, together with a specification of the type of worker needed in each case to perform them. Not only the degree of physical strength and skill, but also the degree of mental capacity, is usually prescribed. The assumption is, of course, that different applicants will be found to possess a varying and measurable degree of native intelligence. Perhaps it also implies that it is wasteful either to put a man on a job for which he is not competent or to squander a brilliant worker upon a job beneath his qualities.

The discovery has even been made by industry that there are feebleminded people, and that some jobs thrive in the hands of the mentally deficient. A well-known button factory has certain monotonous inspection operations to which it assigns feebleminded workers of tested and guaranteed incapacity. Dr. Bernstein, of the Rome State Custodial School, placed out for day's work one hundred feebleminded girls, all but two of whom made good. I have good reason to believe, as you will presently see, that a good many workers who are satisfactorily filling their jobs are really of less than average intelligence, but are under no stigma of feeblemindedness, because their jobs make faint demands upon the intellect.

There may be some who will be surprised to hear that I consider that the whole employment-management movement, which has made itself at home in industry during the last decade, is guided by the point of view of mental hygiene. Its purpose is identical—to substitute for the old policy of hire and fire a more subtle policy of individual adjustment. The policy of transferring from job to job—seen at its extreme with the Ford Motor Company, which will fire nobody, but shifts incapabilities till they find a proper niche—is a recognition of the existence of different levels of intelligence and mental condition. The idea of physical examinations as a foundation for correct physical adjustment, the study of illumination, posture, and fatigue, the establishment of rest periods, the organization of recreation and social activities, and the provision of good restaurant and sanitary facilities, all recognize that health and happiness condition not alone industrial peace, but mental efficiency. These things are not usually called mental hygiene, because of the common misconception of mental hygiene as a subject dealing only with crazy people. But those who know that discontent and unhappiness are the first stages of mental disease realize the import of these measures.

The most outstanding example of mental hygiene in industry was the work during the war of Colonel Brice Disque with the loggers of the Northwest. For years the lumber industry had been a plague spot—a hotbed of I. W. W. outlawry. Carleton Parker diagnosed the trouble as industrial insanity. He said that the loggers were "voteless, womanless, jobless," mentally sick vagrants who were crazy because they lacked decent bosses, comfortable huts, warm blankets, good food, and steady work. Above all, they wanted to have their manhood recognized. They were mostly men who thought with their emotions, and their thoughts were wild because their souls were sick.

The employers never believed him, but when the war made the government interested in spruce, it found that it had to get interested in men. Some inspired intellect in the War Department put Colonel Brice Disque on the job of logging for men. Where did they find him? Running the state prison in Michigan, treating his criminals as so many children or sick people, and they had the courage to put him on the industrial job.

I have no space to tell of the magic wrought by Disque. He made his job a straight-out enterprise of mental hygiene. Not that he examined and diagnosed individuals and gave them pretty thoughts to hold, but that he gave them handsome things to think about—steady work, decent conditions, and democratic self-expression. And the result was that the disloyal I. W. W. became the Loyal Legion, and got out the timber.

Such an example as this makes it easy to see that mental hygiene has a place in industry and is often found there. Colonel Disque's work was a good example of the application of the principles of mental hygiene. Its diagnosis was based upon intuitive recognition, rather than upon scientific scales of values and methods of inquiry. Its treatment was general and wholesale, like a job of public-health work. The psychiatrist points out that general causes make a whole group of people ill, but that special causes, even in a healthy community, make individuals ill. Disease has to be fought both wholesale and retail. You quarantine and vaccinate and clean up to prevent the community from contaminating the healthy individual, and you cure the morbid individual to prevent his infecting the community.

I think we may safely say that modern industry has begun to appreciate that mental conditions have to be studied and psychological remedies employed. No very definite technique is employed. Workers are divided into classes without being accurately classified; mental troubles are doped without being particularly diagnosed. Either the work is wholesale or wholesale generalizations are applied to individuals.

This may be enough. Industry always has an argument against any new proposal in the statement that "it has somehow worried along without this thing so far, and might as well continue to do so." Even if it is true that 45 per cent of the people are morons, no more than twelve years old mentally, what of it? The textile industry used to work children five and six years old. We have in our own mills some old-time workers who began at the age of nine. Their tasks have not changed since, and it is their own affair if they have themselves grown any since. It is only recently that a federal law kept children out of the mills till they were sixteen. The great majority of industrial tasks don't require good minds, but good habits. Why bother about mentality?

Mental hygiene has a reply to this. It tells industry: item one, that the reason the government raised the age limit for child workers was because, even if industry could use workers only nine years old, the state couldn't use voters so immature. It tells industry: item two, that a nine-year-old intelligence can't hold sway over emotions and instincts and a will that may keep on growing to the age of fifty. It tells industry: item three, that most of our crime, drunkenness, and inefficiency is due to the mistake of letting persons with adult impulses and childish intelligences operate without guidance. Mental hygiene in industry, therefore, would not throw out the 45 per cent of morons, but it would throw around them the protecting arm of science.

The very reticent and cautious medical director of the Massachusetts Society for Mental Hygiene—Dr. A. Warren Stearns—has done a fine piece of work to which he has given no publicity. I cite it for its moderation as an illustration of how carefully the true scientist would take up work in industry, even if he were given freedom of action. During the war, Dr. Stearns made psychiatric examinations of some thirty thousand naval recruits at Mare Island. The great mass of them never saw Dr. Stearns. They had filled out cards, similar to applications for employment, on which they gave some details about jobs they had held, schools they had attended, and family relationships. This information, which is called "social history," passed through Dr. Stearns' hands. In most of them he could read normal adjustment to life, and the writers were not interviewed. In some 10 per cent, he thought he saw incapacity to make adjustments easily. These men were tactfully questioned, and a little less than a third of them proved to be unfit for the navy. The remainder were scheduled for further observation, or better assignment, or close supervision. Two or 3 per cent of mental incompetents isn't a large one to make a fuss about, yet any one defective might have lost a submarine or caused an explosion in the boiler room.

Recently I attempted to apply Dr. Stearns' principle of selective inquiry to a group of three hundred employees in an industrial plant. The study was made for me by the employment manager, the plant manager, the plant physician, and the nurse, under the guidance of a graduate student of psychology and mental hygiene. Using the employees' records as social histories, they selected a certain number as probably deficient or probably somewhat deranged. Of these, only twelve seemed to the executives, who knew them, to warrant further study. These twelve were observed, considered with regard to production, conduct, and family relationships, and reviewed in the light of their physical examinations. Ten were classified as probably deficient, but only one as actually feebleminded. Several of these were simply cases of senile decay. Two only were regarded as persons needing treatment for abnormal mental conditions, and only one was recommended for study at the Psychopathic Hospital. Of the whole twelve, five were rated as "very good" in their work, five as "good," and two as "fair." Apparently the assignment of workers in that plant is so good that very few are set at tasks beyond their intelligence. It might, of course, reveal a poor standard of rating workers, when low-grade minds are rated "very good." It is more likely to reveal, however, the ease with which places can be found for the person of tepid intellect.

It would be unwise, however, to assume, because the low intelligence of these people did not affect their rating, that it did not affect their competence as citizens, as members of an industrial organization, and as parents of other industrial workers. To detect feebleminded or deranged workers whenever it can be done, as it was in this case, without disturbing the equanimity even of the suspected ones, seems to me to be decidedly worth while as a guide to physicians and employment managers in their work.

Mental disease is curable, but feeblemindedness is as incurable as big ears. As Professor Goddard phrases it, "every human being reaches at some time a level of intelligence beyond which he never goes; these levels range from the lowest, or idiotic, to the highest level of genius. The number of people of relatively low intelligence is vastly greater than is generally appreciated, and this mass of low-level intelligence is an enormous menace to democracy unless it is recognized and properly treated. The social efficiency of a group of human beings depends upon recognizing the mental limitations of each one, and so organizing society that each person has work to do that is within his mental capacity and at the same time calls for all the ability that he possesses."

Thus the hygiene of dealing with the weak-minded in industry would differ radically from the hygiene of dealing with the mentally sick. The former cannot be educated beyond their intelligence—but they can be fitted to appropriate work and trained in good habits and kept physically fit so that they do not deteriorate to a still lower level. It seems to me that even if the morons of industry do not lower the efficiency of operation, it is nevertheless valuable to tag them, if only to spare us the trouble of trying to force them beyond their capacity.

That part of mental hygiene which deals with the mentally disordered, however, is more difficult, precisely because a cure is usually possible. It is more closely relatable to efficiency because it leads to absenteeism, conscious withholding of efficiency, dishonesty, fights, turnover of labor, strikes, etc. And it is hardly necessary to adduce proof that these inefficient occurrences are frequently due to mental disorders. We have only to broaden our definition of a mental disorder to include the state of mind that produces these things. No one doubts the necessity of studying human motives and instincts to find the key to conduct. There can be no debate, therefore, over the desirability of employing psychiatry to cure mental disturbances, once we admit that psychiatry is the best collected, classified, and tested knowledge about human motives and instincts in disorder. Indeed the hard-headed manager who boggles at the idea of examining his workers to see if there are any "nuts" among them is likely to welcome psychiatry with open arms once he learns that it is concerned with mere trouble makers. Any one who wants to deal with "grouches" and "kickers" and chronic absentees is welcome to his work, even if he does like to regard these disagreeable folk as merely sick minds.

As an employment manager reviewing the question of the practical application of the principles of mental hygiene in industry, I offer the following suggestions: First, that we consider for the present only the modern medical approach to the subject; second, that we strive to clear up misconceptions on the subject of mental hygiene; third, that we recognize wherein we are already employing mental hygiene in industry; and finally that we make a cautious approach toward a more scientific and technical direction of the work we are already doing. The caution is needed not only because we lack experience to guide us, and lack even an adequate body of medical specialists, but also, especially, because the education of the public takes time, and prejudices die hard.

As I view it, this cautious approach would be quite in line with what Dr. Cobb advocated. Obviously, the first step is further enlightenment of the employment managers and physicians already doing a general sort of mental-hygiene work in industry. To this end I suggest conferences of such workers at which papers on the subject are read, if possible by psychiatrists. When these workers are informed, an effort should be made to clarify the minds of general executives on the subject, so that any later steps can be taken with proper assent. Perhaps it will then be possible to make a mental-hygiene survey of an industry. Such a survey would be a study of both the conditions affecting the mental attitude of the workers and an examination of social histories as shown on the records. Only rarely would individual personal examinations be necessary. These would be conducted so as not to indicate doubt of the employee's sanity, and perhaps would be incidental to an interview brought about ostensibly for some other purpose.

Such a survey would then be used as a basis for further study and training or action by the regularly employed service workers. The professional psychiatrist would need to come in only as a consultant and trainer for the other personnel workers. The great advantage of utilizing the regular physician and service workers, instead of a psychiatrist, lies in the fact that inquiries by the former start with the assumption that the subject is normal, whereas questions by the latter seem to imply the reverse. The advantage of having an open-minded, willing subject instead of a rebellious or frightened one, is obvious. The possibility, too, of organized protest against even the most innocent and sympathetic attempt at mental hygiene is clear.

With all due cautions, however, and with all acknowledgements to the present state of the public understanding of the subject, mental hygiene has, in my opinion, a real and important place in industry and offers great promise of public service.

INDUSTRIAL HYGIENE*

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MOST people wish health, and most people do not have it. We have not developed as yet any mechanism by which the disabilities of the sick may be early remedied. We cannot tell for any large group of our population what the extent of sickness is or accurately assign causes for the burden of lost health and usefulness.

Industrial hygiene is the hygiene of the workers in industry; it is concerned with the health of forty millions and more of our people. It is involved only incidentally with the problems of specific industrial disease. It is not so much a thing of itself as it is a way of doing a thing, a way of combating the public ill health, using industrial life as the field of encounter. It carries the art and science of medicine to a great group rather than awaiting the late coming of that group to medicine.

Employers and employees have been given to protesting that personal sickness was a responsibility, even a privilege, of the individual, solely his own concern. It could be that only for an individual who had no place in any social order. It is no longer the height of good form to enjoy poor health.

Statistical evidence regarding the frequency of industrial accidents is staggering. The time loss to workers and their fellows is an impressive and costly total. The loss due to sickness, however, is in the aggregate vastly greater—in many instances five to ten times as great.

It is not the sick man alone who pays—we all pay.

Of non-disabling sickness we can only roughly reckon the extent of severity. Recent studies of the Harvard Mercantile Health Office show that in a number of store dispensaries 60 per cent and more of the store personnel make use of the dispensary each month. This finding suggests the incidence of minor ailments among the populace at large, much of it not as physically fit as the portion in active work.

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* Read at the Annual Conference of the Massachusetts Society for Mental Hygiene on the Human Element in Industry, April 7, 1921. Other papers in this symposium were *Mental Hygiene in Industry,* by Dr. C. Macfie Campbell (see page 468) and *Has Mental Hygiene a Practical Use in Industry?* by Boyd Fisher (see page 479).

All of the disabilities of man are not physical, and the mental disabilities must be of great concern to the worker for industrial health. One cannot consider the findings of the army psychiatrists that 70 per cent of almost two million men had a mental age of less than fifteen years, even discounting it generously, without realizing that handicapped minds, like sick bodies, cause industrial wastage and a vast amount of sorrow and discontent.

Little is known of ways to develop medical service in industry, but less is known of industrial psychiatry. For the psychiatrist there is a splendid job. It promises much in the way of aid in the difficult task of fitting men to the jobs they can best do and jobs to the men they need. Even with such an adjustment consummated, industrial discontent will still be found—but it should be a healthier unrest than we now know and that day a better one than this.

THE MENTAL HYGIENE ASPECTS OF ILLEGITIMACY

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IN the mental-hygiene approach to the problems of an individual or of society, we aim to discover the motive that lies behind every act and to recognize the elements in the personality of the individual that, influencing his attempts at adaptation, modify his behavior. At the same time we recognize that a method of adaptation may possibly symbolize something quite foreign to the act itself. It is absurd to accept the concept of mental hygiene as synonymous with mental pathology, for, indeed, many aspects of the situations that come under observation in the study of conduct constitute essentially normal adaptations. In order fully to appreciate this fact, it is necessary to stress the possibility of discovering in every situation factors that offer an opportunity for successful management and for formulating a constructive program. Thus, in the study of the problem of unmarried mothers, it is pertinent to ask: "What is it, besides the actual sex experience, that leads the girl to indulge in illicit sex relations, and what is it that she seeks in choosing this method of expression?"

To answer this question, it is necessary to distinguish between illicit sex relations as such and sex promiscuity constituting a behavior tendency. The mere fact that a girl has engaged in illicit sex relationships does not justify the assumption that of necessity there need be any pathological mental situation involved. The impression gained that such is always the case in antisocial situations is due, of course, to the fact that we have hitherto had an opportunity to study only highly selected groups of sex delinquents. These girls have come under our care as a result of the necessity for assistance on the part of the community. In these cases we see another factor entering which we must recognize as that of social maladjustment plus illicit sex relations. While we may be justified, therefore, from the study of data obtained in institutions and clinics, in saying that there appears to exist an important correlation between illicit sex practices and mental pathology, it would be folly to generalize and assert that this correlation is indicative that a definite relationship exists in all cases between illicit sex practice and mental pathology. Until such studies are made among diversified groups and in all strata of society, we have no true criteria for judgment. We know—possibly to some degree theoretically—that the problem of sex and sex expression is not confined to the particular group of persons whom we have been permitted to study in the past, but that it exists in every walk of life. The sooner we are willing to accept the fact that sex and sex relationships constitute a practical problem for all of us, the sooner shall we be able satisfactorily to comprehend and intelligently to handle the problem in others.

For the purposes of this discussion, let us leave out of consideration at present those individuals who fall into the first group, in which we have a combination of definite mental pathology and sex promiscuity and probably a definite and important relation between them.

In another group we may include those individuals in whom illicit or promiscuous sex expression exists as a definite behavior tendency. Here this behavior tendency in itself is often so unusual as to justify inquiry into its nature and causes, and, if we are to accept responsibility for management, it should be our concern to ascertain every possible means of satisfactory adjustment. In speaking of mental hygiene in its relation to illegitimacy, this is the most important group for consideration. How, then, may we define this type of behavior from the mental-hygiene point of view?

If we can for the moment rid ourselves of a strong inclination to consider this problem from an ethical point of view, and regard it as a problem of behavior, we will find that it is necessary to apply the same criteria that we habitually use in the estimation of any other kind of a behavior problem. Thus we are justified in assuming, on the one hand, that there may be conditions in which a pathological state of sex equipment exists—that is to say, an undue and disproportionate urge for actual sex expression—while, on the other hand, we may have a girl with essentially normal sex equipment in whom there is a lack of ordinary inhibitions, for we must accept the fact that most individuals possess sufficient inhibitory powers to assure proper adaptations with reference to their sex lives. We know that there are individuals in the former group who are naturally excessively equipped sexually. We have definite physiological proof that there may exist certain misdevelopments or misfunctionings of the internal glandular system of the individual which result in a precocious sex development and, accompanying it, an undue intensity in the sex requirement. Here, of course, the situation is relatively simple in its explanation if not in its management, for it can be looked upon from a purely medical point of view.

One's intense sex cravings may not depend upon these purely physiological difficulties, however, but may arise from the use of one's sex equipment in an effort to overcome certain thwartings of activities in other directions. Because of an abnormal conditioning influence in the sex development of the individual, either sex control or normal sex expression may be made difficult, if not impossible. It may be the case that, as far as an individual is concerned, illicit or promiscuous sex life is the only kind of sex that can be indulged in with any degree of satisfaction.

For example, consider a girl in a family with a number of other sisters. An older sister may throughout this individual's memory have received more attention, more thoughtful care, more opportunities for social adulation, more attractive clothes, and more recreational outlets, while younger sisters, because they may serve mother and father as outlets for instinctive parental cravings, may be objects of envy. Soon we may have such a girl thinking that she is not as desirable as her sisters. She may develop a "grudge attitude" and feel that in her experience outside the home an opportunity is presented to obtain compensation for the things which the home fails to supply. When she reaches the age at which she gains renewed impetus for self-expression as a result of the adolescent urges and newly awakened emotional strivings, she will seek an opportunity for social outlet. It is in just such cases that we do find, at times, girls entering into lives of sex promiscuity in a definite attempt to find some means of compensation for the imagined unjust situation in the home.

The second group includes also the girl who, from early difficulties in making adjustment to the family and social situations, reacts by developing a sense of inferiority. After repeated failure in making adjustments that appear satisfactory to her and finding that in certain instances, in the competition of life as she sees it, she does not measure up to the standard which the other members of the household or the small community in which she lives set for her, instead of accepting her apparent limitations and so organizing her known abilities that she can successfully compete along channels of her choice, she blindly seeks some way of "putting herself across" in the community. If she finds that this can be done through the medium of sex expression, in many instances she accepts this as the most satisfactory means of self-magnification—in other words, she accepts the life of sex promiscuity in a blind attempt to compensate for the things with which life in other phases fails to furnish her.

In the light of the recent knowledge of psychopathology, we cannot fail to recognize that sex factors may enter into the father-daughter and mother-son relationship. Because of a type of pathological attachment to the father, a girl may find, when she expresses her true sexual interests, that all other men are sexually unattractive, and if she permits her feelings free play, may be inclined to submit herself to promiscuity. In a recent report of the Chicago Vice Committee on the study of a group of prostitutes, it was found that about 50 per cent of the girls had been seduced by their fathers or other adult male relatives. Thus such interests on the part of these girls bear directly upon the problem of prostitution. In some instances it may be conceived as a substitutive process and in others possibly as an unconscious protest.

Now let us consider those individuals with assumedly normal sex development who lack the normal inhibitory equipment. We must accept this type as belonging to a group with a definite pathological basis. With this conception we are justified in looking for a pretty definite correlation between feeblemindedness and illicit sex practices, but we must be cautious about seeing cause-and-effect relationships where perhaps only correlation exists. In the attempt to seek a satisfactory solution of this problem, we should look for a social-environmental situation in which special safeguards may be thrown about such individuals. In other words, feeblemindedness in the problem of unmarried mothers or illegitimacy is largely a matter of maladjustment. We have, for example, the group classified as imbeciles and low-grade morons, who have little more interest in sex matters than children of their corresponding mental age. The problem with such persons consists largely in protecting them from becoming innocent victims of the sex activities of others. The solution of the problem is early recognition and adequate institutional or other supervision of girls who, in unsatisfactory home environments where the moral codes are appreciably low, receive unintelligent treatment and are exposed to all kinds of harmful contacts.

Another group is made up of higher-grade defectives, frequently of attractive physical make-up, who, because of their narrowed general interests, frequently endow their sexual phenomena with added significance. Since sublimational channels are few and unsatisfactory, such girls receive little satisfaction from their meager intellectual endeavors and often voluntarily seek expression for their sexual desires in promiscuous sex relationships, with little or no vision of the responsibility incurred in probable motherhood. In a recent survey of a House of the Good Shepherd, where girls of sixteen and over receive court sentences for periods of six months or a year, I found among the white girls there approximately 43 per cent of feeblemindedness and among the colored group 71 per cent. This is of special significance when, on studying the sentences, more than half were found to have been convicted of prostitution (or "associating with immoral persons," a classification that has less social stigma attached, but means the same thing). It is not conceivable that, at the expiration of their sentences, there will be much appreciable change in the social attitude of these girls and certainly no variation in their original mental endowment. The only satisfactory means of controlling this phase of the problem of illegitimacy will come when the judges accept the significance of a competent medical diagnosis of mental deficiency and accord a defective girl opportunity for care in an appropriate institution or for adequate community supervision. One is often asked if feeblemindedness carries with it a hyper-sexed state. In some feebleminded individuals we find this to be the case. This, together with the absence of normal inhibitory faculties, tends to create important sex problems.

When we consider the problem of sex control in its widest aspects, we must conclude that only those individuals who are biologically well adjusted, and whose sexual cravings are so conditioned that in their strivings toward gratification the output of energy is normally utilized in the reinforcement of the ego struggle for social esteem, can be considered as possessing the key to satisfactory adjustment. We are, then, led to believe that no individual can have an anxiety neurosis so long as she can maintain her sexual potency without jeopardizing her need for social esteem. If the girl can maintain her sexual potency only at the price of social esteem, she may become a social delinquent. If, on the other hand, sexual potency is sacrificed for the sake of social esteem, an anxiety neurosis may develop unless the sexual striving can be thoroughly sublimated. Thus it is that our problem of education toward a satisfactory social adaptation should begin before the girl has reached the stage of motherhood. Sublimational outlets must be furnished before the damage is already done; this course offers the most effective means for the control of this problem of sex promiscuity.

In the psychoneurotic group, in whom this type of behavior may be a response to undue repressions at various times, promiscuity in sex may be taken as a state of emancipation or freedom from former repressions. The organically or functionally inferior individual must make an adequate compensation that will not only win in competition, but also win the social esteem of her associates. If this cannot be accomplished, there always exists a conscious sense of inferiority. The compensation which the individual must achieve may in some cases show itself in illicit sex practices, for in such practices the individual protects herself with a sense of superiority over her associates, since she can in this way receive more attention from male admirers.

In the sex problems of psychopathic individuals, some of the same principles can be applied, for in the individual's equipment and organization there are often evidences of failure to measure up to the standards conceived by that individual as existing in others.

In the epileptic states we find dissociation of the personality, infantile irresponsibility, poor judgment, and unstable emotional equilibrium—all capable of directing the epileptoid personality into various experiences in which sex factors may be prominent. With such individuals also we may find that attempts at adaptation along socially accepted channels fail, and they, too, find compensation in promiscuous sex indulgence.

Finally, there still remains an apparently large number of normal girls who deliberately accept their sex attributes as a forceful means of putting themselves across in the community. Here, it would seem, lies much of the real problem of illegitimacy and prostitution. We must ask ourselves to what extent society has given its approval to this means of self-expression as an opportunity for gaining esteem in life before we can classify such conduct in any terms suggesting deviation from health.

What is there that mental hygiene can do in a constructive way in dealing with some of the complex problems that have been indicated? The very fact that mental hygiene emphasizes the principle that there is a cause back of every phenomenon in human behavior ought to give the worker in this field a kind of open-mindedness and freedom of action that cannot be the case when the problem is approached with emphasis only on the conventional ethical point of view. Working from the mental-hygiene point of view, one is more likely to take an objective attitude toward the problem, while if it is approached from the other viewpoint, the element of emotion enters into the worker's own examination of the facts so that success is achieved in inverse ratio to the degree of emotion involved. The mental-hygiene approach involves, further, the principle that no phase of the native equipment of man or woman can be managed adequately by mere denial of its existence. The individual must be able to accept himself as he is, recognizing his limitations together with his assets. In doing so he is obliged to recognize certain urges within himself that must be curbed and controlled. These urges can be handled successfully only when they receive recognition of their existence and are directed into socially acceptable channels. For example, it is pure nonsense to tell a girl that she must not think of sex, must "put it out of her mind" or "forget about it," when a strong tendency within herself draws her attention continually in this direction. What one wants to hold out is the possibility of the management of these urges in a manner acceptable to social dictates. Success in dealing with cases of this type depends largely upon the ability of the worker to explain and to help the individual to make the necessary personal adjustments. We will become more liberal-minded and consequently more effective if we take into account the great number of potent sex forces, and recognize that, while by nature and trend of thought we all are driven in the same direction, through insight into the management of these urges we may discharge troublesome tensions through socially accepted channels. One must go a step further and recognize that there is always the possibility of utilizing this driving force, common to each one of the human race, for the most constructive as well as the most destructive purposes. Often, where this creative force is utilized along destructive channels, it is not so much through mere viciousness or pathological tendencies as through mismanagement and principally lack of insight into the nature of the problem that actually exists. On the other hand, it would be extremely fallacious to assume that a problem is solved merely by gaining insight. The real task for workers in this field is the task of translating "insight into influence." Unfortunately the principles by which one can accomplish this task are far from being fully developed. One of the fundamental requisites for a worker in this field, before she can hope to achieve any satisfactory results, must be a thorough adjustment of her own sex life. It is believed by some psychiatrists that the most satisfactory worker and the one who can bring the most forceful influence to bear upon problems of illegitimacy is the married woman, for to her have been accorded not only an opportunity for a normal and legitimate outlet, but ability to secure and retain an open-minded, objective attitude. Not all married women have these happy attributes, however. The really essential thing is a satisfactory adjustment of one's own sex life, even after many difficulties, and an objective point of view.

In the satisfactory solution of the problem of the unmarried mother, we must search for the basis of her maladjustment not only through the study of her social and environmental setting, but, most of all, through a careful investigation and study of her personality. This can best be done by an individual with mental-hygiene training. In order to protect the girl from the necessity of numberless interviews and uncomfortable experiences, it would seem expedient in every large community for an organized effort to be made by the agencies in contact with this problem to create a center for a special study of girls under their care, this study to be carried on by a well-organized team of workers, including a psychiatrist, a psychologist, and a psychiatric worker. As a result of the careful studies and the determination of causative factors that could be carried on in such centers, it will often be possible to make more satisfactory classifications and furnish means by which a girl may be aided in understanding her problems, finding satisfactory sublimational outlets, and making more satisfactory social adjustment. We must not lose sight of the fact that in the pregnancy itself we may find a potent factor for good. All women are endowed with a maternal instinct, and as the physiological processes continue during the prenatal period, certain psychological influences are also at work and the maternal desires gradually unfold themselves. If, through our efforts, we furnish this mother with an unstigmatized opportunity to remain with her child, to assume the responsibility of its care, to have a normal outlet for the pent-up love craving, we will discover that much sex hunger can find a normal outlet through the sublimational channels of mother love. This fact should be borne in mind when we consider the problem of child placing, for the normal outlets furnished through motherhood may serve to determine the satisfactory future adjustment of the girl, while, if we ignore this opportunity, she may find no adequate satisfaction except in return to her former illicit sex practices.

It is my purpose merely to urge the importance of seeking to discover the motive behind every act and to recognize the elements at work in the personality of every individual who comes to attention because of failure in dealing with the problems of life. In such studies, which require what I have termed the "mental-hygiene approach," we may often find the key to the real situation in the problem of the unmarried mother.

THE EDUCATIONAL VALUE OF PSYCHIATRIC SOCIAL WORK*

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AS an organized activity requiring special preparation and known by a name of its own, psychiatric social work has come into existence only within the last five years. Its function in relation to psychiatry has become fairly well defined, but its place among other branches of social work is not yet generally understood, and the lines of its future development are not yet clear. In considering the influence that psychiatric social work may exercise, it is therefore necessary to take account of what it is and what it may become. For its influence we will naturally look among those groups with which its workers are in closest association—physicians, social workers, and the general public.

As an unsystematic endeavor, psychiatric social work is as old as psychiatry, for psychiatrists have always of necessity taken account of social conditions both as cause and effect in the treatment of mental disease and have attempted as far as possible to follow their patients into the community. In many hospitals the need for better facilities for attention to social aspects of the cases was keenly felt years before special provision was made for it. When in time certain hospitals were ready to introduce a social service, they naturally looked for the personnel of this new department among social workers, who had been specially trained to deal with social conditions. The principle of the social service was not merely an extension of the doctor's efforts to deal with social factors, partial and spasmodic of necessity, but an attempt to introduce into the plan for patients' care the point of view and special knowledge and technique of the social worker. The doctor added to his equipment an assistant trained in a special field.

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* Read before the Mental Hygiene Section, National Conference of Social Work, Milwaukee, June 28, 1921.

The place of psychiatric social work in the mental hospital or clinic is now well established as an aid in diagnosis, treatment, and research. A committee of psychiatrists and social workers which met last summer under the auspices of the National Committee for Mental Hygiene to consider the function and training of the psychiatric social worker defined her function as follows: (1) to facilitate admission to hospital or clinic and continuance of treatment; (2) to bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment; (3) to assist in carrying out treatment; (4) to interpret hospital and clinic to patient, family, and organizations of the community; (5) to make social investigations contributing to medico-social research.[1] It is evident that with assistance of this kind the psychiatrist has greatly increased his facilities for both the study and the treatment of mental disease.

In relation to social work, the function of the psychiatric social worker has not yet been defined. In discussing this relation, it is first of all necessary to consider the nature of social work. The time is past when social work was conceived of as consisting merely of practical measures for the prevention and relief of distressful situations caused by poverty, sickness, and crime. This is the idea embodied in the old name of the conference—Charities and Corrections, and it went formally out of existence in 1917, when the name was changed to National Conference of Social Work. But social work is still not quite sure of its identity and in any gathering to-day of social workers, teachers in training schools for social work, and professors of sociology, the question never fails to arise: "Is social work really a profession?"

Many persons both in and out of social work believe that there *is* now a profession known by the descriptive term "social work," which is in the early stages of its development, and that this profession calls for specially trained persons devoted to the discovery of scientific principles for its guidance and to practice in the application of its principles for the improvement of society. But there are many social workers who have not yet answered this question even to their *own* satisfaction. The answer will depend on the practical consideration of whether the world needs a professional body trained for a service not already provided for, in theory at least, by the other professions—medicine, education, theology, and law. In a sanitary, educated, moral, law-abiding community, would there be any demand for professional social service? Or, if by accident, by failure to use opportunities, or by misuse of them, a certain number of the population fell into social disorder, could not these problems be met by doctor, teacher, clergyman, or lawyer, with the social consciousness that every practitioner of this enlightened future is expected to have and with some lay assistance to eke out his time? The state of society here suggested is at best very far off, but we do well to base our conception of social work upon principles calculated to survive the centuries. The future of social work depends upon whether the established professions, in theory at least, functioning to their utmost capacity, are sufficient for the prevention and cure of social disorder.

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[1] See *Function and Training of the Psychiatric Social Worker.* MENTAL HYGIENE, Vol. 5, pp. 434-5, April 1921.

Let us consider what the social worker does. All the varied activities that come under the name of social work fall into three major divisions of endeavor: (a) to help the individual in social difficulty—*social case work;* (b) to promote social consciousness among groups—*community work;* (c) to improve community conditions—*through research, organization, legislation.* The common factor in all three divisions is the study of human relationships with a view to the better adjustment of individuals and groups to their environment.

We are here chiefly concerned with the first of these major groups, social case work, for it is within this field that psychiatric social work has developed. Its place in neighborhood and community work has not yet been found. How far the psychiatric social worker will enter into group leadership and community organization is a question for the future. To some extent she has already taken part in community mental-hygiene surveys, notably in the investigations conducted by the Canadian National Committee for Mental Hygiene. And at least one neighborhood-house director has expressed the opinion that there should be a psychiatric social worker upon the staff of every neighborhood house.

Social case work is an effort to bring a person suffering from social difficulty into a sound social condition—that is, to borrow an expression I once heard, into a condition where "he can operate freely in an environment he has learned to control." The method of social work is (a) examination of the past life and present condition from data secured through investigation and observation; (b) analysis of these facts to determine the fundamental causes of the trouble; and (c) a plan of treatment by which all the elements of the individual's life are so organized as to effect the best adaptation to his environment that is possible for him. Social work, then, is equally concerned with all aspects of life and with all human relationships. Each of the four great professions of medicine, education, theology, and law, while also promoting the adaptation of man to society, has for its function attention to some *particular* aspect of human life and, although in dealing with an individual, it must necessarily take into consideration all sides of his life, all other aspects are subordinated to that one which is its particular concern. Social work is the only activity which deals equally with *all* conditions and *all* relationships of life.

The social worker must know enough about all the arts and sciences to be able to see that his patient or client has the benefit of them, and must render a further service, which is not simply connecting or amplifying *these other forms* of service, but is a *special kind* of service not afforded by any other practitioner. The special expertness that the social worker contributes is knowledge of how to effect adjustments between individuals and their environments and skill in bringing about such adjustments.

The patient or client who has come to the social worker for assistance may have difficulties in all of the five spheres of the "Kingdom of Evils,"[1] the classification that Dr. Southard devised to comprise all of the evils that exist—Disease, Ignorance, Bad habits, Legal entanglements, and

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[1] Southard, E. E., M.D. *The Kingdom of Evils: Advantages of an Orderly Approach in Social Case Analysis.* Proceedings of the National Committee of Social Work, 1918.

Poverty or Resourcelessness. The patient may be sick, ignorant, morally untrained, in difficulty with the law, or without resources, financial or otherwise. Whatever specialists may be needed in the case, the social worker deals with all of these conditions and reconstructs the total situation to the end that the patient may get on as well as possible.

The characteristic function, then, of social work is to know what constitutes sound social condition and how to secure it. Not a specialist in health, education, morality, law, or economics, but knowing something about each of these fields, the social worker is a specialist in the field of social adjustment. As society becomes more complex and the possibilities of maladjustment increase, at the same time our perception of what constitutes a sound social condition becomes finer. In the medical field, while the possibilities of disease increased, knowledge of causes of disease increased also, and higher standards of health were demanded. So in the sociological field may we not expect increasing possibilities of maladjustment, but at the same time better knowledge of causes of social disorder and the demand for higher standards of social life?

The professionally trained worker in any field is quick to see the earliest indications of trouble. The trained social worker now sees the potentiality of social disorder in signs that the unpracticed observer would not notice or would not elicit. In the future may we not expect that social case work will become preventive in the sense not only of correcting early signs of social trouble—which it is doing to some extent at present—but also of teaching principles of social adaptation and proper ways of meeting situations?

Experience in social work in hospitals has shown that it is not only groups below certain educational and economic levels that need the services of the social worker. Economic and educational factors do not determine the need for social assistance; therefore, it seems probable that in time social work will be a form of professional service available for all classes for both preventive and curative purposes.

This improved knowledge of what constitutes sound social condition and how to secure it must be gained through the study of individuals. However important the influence of the group mind may be upon individuals, still the nature of the group depends, after all, upon the character of its units, and the action of groups is significant ultimately only in its effect upon individuals. All community effort has for its final purpose the welfare of individuals. In studying how life may be lived most successfully in a society, it is not enough to study only groups and communities, but we must go on to study the adaptation of individuals. From the social worker, who is the special practitioner in this field, should come eventually contributions to a new phase of sociology dealing primarily with individuals. Social case work may then be recognized as the art of applied sociology.

The fact that our theory and practice in social work are as yet poorly developed and crudely applied does not indicate that future progress will not follow lines of development similar to the history of other professions. In 1873 Herbert Spencer published a book which he began with the question: "Is there a social science?" Nearly fifty years later, we are face to face with the question: "Is there a social profession?" Sociology has now an established place among the sciences, although rumblings of Spencer's question are still heard in some quarters. We social workers of to-day are like the little creeks and rivulets that in the end go to fill a great reservoir. Perhaps another fifty years will see social work an established profession founded upon a science of sociology greatly developed in its individualistic phase.

If it be true that the task of social work is to promote social adaptation through the adjustment of human relationships, what is the place of psychiatric social work in this endeavor? The point of view of the psychiatric social worker is derived historically from the mental-hygiene movement, just as the point of view of the medical social worker is derived from modern developments in medicine, and the point of view of social work in general from the older philanthropic activities founded upon economic necessity. Upon this foundation of interest in the economic security of the family was laid the emphasis of medical social work upon health and upon the effects of disease in causing social maladjustment, leading to greater attention to the individual members of the family group and to a more profound view of social troubles. The recent emphasis of psychiatric social work upon mental health and the relation of mental disorder to social disorder has begun to make its impression upon the point of view of social work in general. There is beginning to be a widespread recognition of the fact that complete study of a person involves attention to the economic, physical, and mental factors of his life and situation, and that it is not enough to treat him scientifically from the standpoint of economics or medicine and leave the consideration of his mental condition to intuitive or common-sense methods. A large proportion of applicants for social assistance have some mental condition that would be counted as disease and that should receive the attention of a psychiatrist (50 per cent is probably a very low estimate); but it is not only in the treatment of psychiatric cases that the social worker in general needs the point of view and knowledge of psychiatry. The study of human relationships and the art of adjusting right relationships have their foundation in mental attitude and personality, and future progress in social work will be based upon the understanding of mental processes. This knowledge must come from psychology and psychiatry—not from one of these fields only, but from both. Just as the social worker must know something of medicine as well as of biology, so some knowledge of psychiatry is necessary in addition to psychology for understanding individual personalities.

When every social worker shall have acquired this knowledge as part of her regular training, will there still be need of a specially trained body of psychiatric social workers? The practical consideration that certain social workers will elect to work in the field of mental hygiene in assistance to psychiatrists would seem to answer this question. Through the study of pathological cases, principles are discovered that may be applied in all cases. It should be the function of the special psychiatric social worker dealing with psychopathic patients to find principles and methods for the improvement of human relationships that might be applied in the whole of social work. We see to-day the beginnings of this tendency. The director of a family agency, which employed a psychiatric social worker upon its staff to deal with psychopathic cases, said that the greatest benefit derived from the psychiatric social worker, even more valuable than her own direct work, was an improvement of all the case work in the agency through her influence.

It is especially desirable that the psychiatric approach to case work should be stressed in those fields of social work that are preventive rather than curative. The two great opportunities for preventive social work are in the school and in industry. In each of these fields social practice has to be adapted to the special conditions of educational and industrial organization, but the principles and essential technique of social case work are employed. The cumbersome name "social worker" may become submerged in a name that designates the special function performed.

There is a movement now well under way in the schools to provide a social service through visiting teachers. The visiting teacher is essentially a social case worker familiar with educational methods, in some instances through having been herself a teacher. It would seem to be of the greatest importance that the earliest practitioners in this field should be well grounded in the principles of mental hygiene in childhood. The right of the child in school to protection in matters of general hygiene has been recognized and practical measures for the health of school children are being introduced as fast as possible. But so far there is very little recognition of the child's right to mental hygiene. One of the most effective ways of carrying mental-hygiene principles into the school would be through the visiting teacher, who deals with the child in all parts of his environment—school, home, and community.

In industry, the function of the personnel worker is essentially the function of the social worker. His aim is to keep the employee adjusted to his work. To do this successfully, he must take into consideration personal and family conditions; for the way a man gets on in his work depends upon the adjustment of his personality, not only to the conditions of his employment, but also to his home conditions. Any form of social disorder will interfere with a man's working capacity. The personnel worker should seek to help the employees to preserve that total social adjustment which will promote both their happiness and their efficiency. He is continually called upon to make social diagnoses, usually upon an incomplete social examination. It is not usually possible at the present time for him to make a thorough social examination of every employee who shows symptoms of social difficulty, both because the staff of the personnel department is not sufficient for the required outlay of time, and also because public opinion still looks askance upon the social examination. There was a time when a thorough medical examination was often regarded as a personal affront. In time the prejudice against a thorough examination of a person's social condition by a professional adviser will doubtless be outgrown. Meanwhile the personnel worker who is called upon to make snap diagnoses is all the more in need of the skill and keenness that come from practice in intensive social work.

It seems particularly important that the industrial social worker should have experience in psychiatric social work—special training, that is, in the study of personality. The connection between personality and employment is one of the most vital human relationships, and it is impossible to think of successfully fitting a man to his work without understanding the nature and habits of his mind. The personnel worker, who has this function to perform, should have the benefit of all the knowledge that psychiatry can contribute to social work.

In the prevention of social disorder the personnel worker equipped with the point of view of mental hygiene has a large opportunity both to preserve happiness and promote efficiency. Temperamental difficulties, peculiarities, unfulfilled longings, disappointed ambitions leading to conduct that makes trouble in the shop and creates involved situations at home, when properly understood and dealt with from the psychiatric standpoint, may often be rendered quite harmless. The promotion of mental hygiene of industry would do a good deal toward the prevention of social disorder.

The general public is at the present time highly receptive to ideas of mental hygiene, to such an extent that any practitioner or panacea advertised with assurance as a mental help readily gets a following. At the same time there are comparatively few persons who regard mental disease with the same objectivity with which they regard physical disease. And most persons still think of mental hygiene only as a means of avoiding mental disease. The social worker is probably the best agency there is for spreading better information concerning mental health and mental disease. In every case she deals with she interviews numbers of persons, anywhere from five to twenty-five, possibly. Both by her attitude toward the patient in question and by what she tells about him, she leaves behind in every interview an impression that the trouble is a disease to be regarded as other diseases. Moreover she has countless opportunities to talk with family, relatives, friends of patients about mental hygiene as a means of increasing happiness and efficiency. This responsibility for public education should be consciously part of the duty of the psychiatric social worker in particular.

In considering the educational value of psychiatric social work to the community, I have spoken only briefly of its influence upon psychiatry and upon public education and have discussed almost entirely the influence it is exerting upon social work, because the benefit to the community of this latter influence will, I believe, outweigh in extent and importance all other effects that psychiatric social work may have.

MENTAL HEALTH CLINICS*

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THE realization of the importance of mental health to the welfare of the individual and the community has grown at a rapid pace as a result of the experiences of the past few years, and yet even to-day the far-reaching importance of this factor is but vaguely appreciated and for many people the term arouses little more than thoughts of insanity and feeblemindedness. These two varieties of mental ill health, though striking and more or less obvious, are but a fraction of the real problem. The size of it is better indicated by stating that the ability to adjust to the conditions of social life, to subordinate the individual to the good of the group, and to find an outlet with satisfaction for those longings and cravings which are innate and inherent in life itself without harm to social relationships is dependent upon mental development.

Even in such an organization as this conference, the continued existence of a section devoted to mental hygiene has been somewhat precarious, possibly because psychiatric problems are so universal in social work that every section is vitally concerned in them. While it is probably true that a small proportion of social work is rendered necessary as the direct outcome of illness, accident, or defect, yet it is becoming increasingly evident that the great bulk must be referred to mental ill health. The problems presented by the former group are relatively simple, but where difficulty in satisfactory settlement is met, there will always be found some mental problem. While it may not be quite true to say that every case in need of social service is a psychiatric one, the reverse—that every psychiatric case is a problem in social adjustment—is unquestionably true. Social existence, with the necessary control of individual desires that it implies, is impossible without a corresponding mental development, in which is included not merely intelligence, but also the manner in which this is used. In other words, psychiatry is the science of behavior.

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* Read before the Mental Hygiene Section, National Conference of Social Work, Milwaukee, June 28, 1921.

Obviously, behavior must depend partly upon the tools with which the individual must operate—the health and efficiency of the various organ systems of which the body is composed and especially of the nervous system, which serves to select and coördinate the activities of the others into that integrated whole which we call behavior—but this is not all. Good—that is to say, socially acceptable—behavior may exist in spite of even severe organic handicaps and, conversely, unsocial behavior—insanity, crime, etc.—may appear in spite of well-formed and healthy organs. Behavior also depends in part upon training and experience in the use of the organs available. Such a conclusion seems to me unescapable in spite of the time-honored dictum of *mens sana in corpore sano,* which, in my opinion, has done much to retard the development of psychiatry.

All persons are not born with an equal equipment in the way of working tools or of vital energy. Hence it is readily intelligible that, even with identical opportunity in the way of training and experience, some individuals will surpass others in the successful adjustment of their innate personal desires to the restrictions of society. Some are so poorly equipped with nerve connections or so differently constituted in that elusive, but intensely important, quality alluded to above as vital energy, however it be determined, that shipwreck is certain under the ordinary routine of life and training, even though these are satisfactory for the average person.

It is of practical importance in connection with the establishment of the mental-health clinic, to note the interest that has developed in tests of intelligence, not only as scientifically standardized by psychologists, but also as used by employers of labor and others. Unfortunately these tests have been pushed into a prominence and given a significance that does not belong to them, with the consequence that their very real value is liable to be forgotten in the failures that follow from too large claims for their applicability. As a matter of fact, whether overtly or covertly, these tests, when used alone, are usually supplemented by personal estimates of behavior characteristics not founded upon the tests, but included as a part of the report of the findings. Such tests are measures of endowment of a certain kind, and as such are of the greatest value in assisting to determine explanations for behavior and the limits of plans for its improvement and development.

While it may be unnecessary before this audience, it is important for our purpose to insist upon the need for a conception of mentality that does not regard the "mind" as a separate and distinct organ or entity. Mind is not a thing, and hence is not subject to disease as this term is usually understood. Mental activity represents only the activity of "the body as a whole" under the guidance of individual experience and training. These last are effective chiefly through nerve connections in the brain which, when in action, are consciousness. Mind is therefore not a separable, independent entity, a realm in which guardian angels and evil spirits struggle for victory, nor is it governed only by inheritance and thus the special field for eugenics and euthanasia. In studying mentality, it is necessary to take into account not only the endowment with nerve connections of the brain (intelligence) and lower parts of the nervous system, together with all the various body organs, but also the training the man has received by his individual experience in the use of these endowments. Furthermore it is obvious that treatment of mentality must be fundamentally educational in the broadest sense of that term, due consideration being given to deficiencies and handicaps in endowment or arising from disease or accident.

Mental health must, therefore, be the most important factor both for the welfare of the social group and the happiness of the individual. Its province extends far beyond the realms of insanity, which represents only certain forms of mental ill health that require segregation from society because of the dangers that result from his behavior to the patient or his surroundings. It enters into the immense fields of dependency, delinquency, and crime, and furthermore it is concerned with untold numbers of chronic invalids, usually grouped as nervous or neurotic, who form such a large proportion of the clientele of the general physician and the specialist, as well as of irregular practitioners, fakers, and the various cults. Clinics (the word implies the presence of beds, but this true meaning is now practically eliminated by usage) for the study and treatment of diseases of various parts of the body have long been in existence, and it seems but logical that others devoted to the study and treatment of the man as a whole, his behavior, are at least equally important and equally medical. Yet the number in existence is extremely small and those largely of recent development. The problems are as yet but poorly defined, and it is probable that experience will bring many modifications and developments in the near future.

Before discussing the needs in general terms, it seems wise to illustrate by actual experience. For this purpose I will quote some figures derived from 100 consecutive cases seen at a clinic maintained in Chicago at the dispensary of the College of Medicine of the University of Illinois, with the coöperation and assistance of the Illinois State Department of Public Welfare. Under this plan, which is as yet only partly in operation, there are maintained two separate clinics; one, for the study of children, known as the Institute for Juvenile Research, is under the direction of Dr. H. M. Adler, who is also criminologist of the department, while the other, for adults, is under my own direction. It is from the latter that these figures are taken. This clinic has been developed in the department of the general dispensary devoted to nervous diseases, and for that reason possibly receives more strictly neurological cases than might be true in a clinic developed primarily for mental health. The combination, however, seems to be an excellent one, for the reasons that it helps to diminish any objection there might be upon the part of patients to a clinic bearing the title psychiatric or psychopathic and that a large proportion of the patients of any neurologic clinic are strictly mental cases. At the present time, the clinic is handicapped by the absence of beds and wards for the special observation and study of suitable cases, though a hospital for this purpose is now in course of erection. There is also an absence of some desirable facilities for treatment, the lack of which is felt continuously. These also will be provided in the new quarters.

In Table I have been grouped the reasons that led the patient to come to the clinic. It must be understood that many of the cases might well be included in several different groups, but it was thought best to indicate only the problem that seemed to stand out most prominently in each case.

TABLE I

Problems Presented

Inability to manage home	7
Friction in the home	10
Sex and other delinquencies	8
Dependency	6
Failure in work	7
Mental excitement	5
Despondency	3
Fits	6
Bodily complaints	43
Special reasons	5

Under the heading of bodily complaints have been placed not only the more strictly neurologic difficulties—such as paralyses, blindness, etc.—but also many psychoneurotic complaints—such as nervousness, insomnia, headache, etc.—which have led the patient to seek assistance on his own initiative or on the advice of friends or physicians. Such cases often have not as yet become definitely social problems to the general public, but they are inefficient, more or less dependent, and, where money is scarce, are liable to become burdens upon society, very probably dragging others with them. Under the heading special reasons have been grouped cases referred for Wassermann or other tests or for examination as to fitness for mothers' pensions, etc.

It will be noted that 38 per cent were referred because of definite difficulties in social adjustment and an additional 8 per cent because of mental symptoms that caused upsets in the social environment. Thus approximately one-half the cases have already been recognized as social problems.

The diagnoses reached are shown in Table II.

TABLE II

Types of case

Mental deficiency	26
Defective delinquency	4
Inadequate personality	1
Epilepsy	5
Psychoses with organic brain disease	4
Psychoneuroses	26
Dementia praecox	6
Manic-depressive reactions	4
Neurological cases	18
General medical cases	2
Negative findings	4

It will be seen from this table that mental deficiency, combined with the related groups of defective delinquent and inadequate personality, constitute about one-third of the cases. The psychoneuroses come second, and it is of interest to note further that many of the cases placed in the group of mental defectives also presented psychoneurotic symptoms. This is undoubtedly due to the fact that the struggle for existence and self-expression under social regulation is rendered much more difficult by reason of the lack of intelligence.

In Table III is given a list of the agencies concerned in bringing this 100 patients to the clinic. It is not a complete list of those which have referred cases, but it is a sufficient indication of the widespread relations concerned.

TABLE III

Agencies by which referred

Other departments of dispensary	22
Institute for Juvenile Research	4
Juvenile court	3
State attorney's office	1
Jewish Social Service Bureau	26
Illinois Society for Mental Hygiene	3
Visiting Nurses' Association	3
Juvenile Protective Association	2
United Charities	5
Immigration Industrial Commission	1
American Red Cross	1
St. Vincent's Orphanage	1
Northwestern University Settlement	1
Social-service department of industrial corporation	1
Voluntary application or physician	26

The character of the treatment recommended is shown in Table IV. The social supervision, in the great majority of instances, has been furnished by the particular agency that referred the patient to the clinic; in a small minority by workers attached to the clinic.

TABLE IV

Treatment recommended

Institutional	13
Social-service supervision	39
Transfer to other dispensary departments	7
Treatment in the clinic	41

It is probable that commitment to an institution for the feebleminded would be recommended in more cases were it not for the fact that there is no space available for such cases in the state. Almost all the cases of mental deficiency belonged in the higher grades of the moron or border-line groups, and many of them were married, with families of varying and often constantly increasing size. It is this last factor that renders them especially difficult, not only because it tends to the development of a steady increase in the numbers of the feebleminded, but also because the increasing burdens soon outgrow the parents' earning capacity and ability to plan, and there is liable to ensue desertion, dependency, illegitimacy, etc. If the growth of these families could in some way be curtailed, many of them could remain more or less completely self-sustaining, useful, and at the same time satisfied, and thus without menace to the community. These remarks, of course, do not apply to those cases where there is at the same time a habit of delinquent behavior. Under existing conditions, it has been necessary to make the best disposition of such cases that seemed possible by providing supervision of household expenditures and plans, assisting in employment, supplementing earnings, etc.

In addition to work with new cases, there is also a large field for the mental-health clinic in the after-care and supervision of patients when paroled or discharged from state hospitals. None of these have been included in the above 100 cases. The homes of such patients are often far removed from the hospital, and in addition there is often considerable reluctance towards returning, even for a visit.

These preliminary considerations seem to justify the following general statement of the requirements for such a clinic. Its purposes may be defined as:

(1) Diagnosis;
(2) Treatment without interruption of social relations;
(3) Early hospitalization where advisable;
(4) Continued treatment after de-hospitalization;
(5) Research into the causes and treatment of mental disorder.

By diagnosis is meant not merely the placing of a name upon the particular type of mental disorder, but also the determination of the factors that have already led, or are liable to lead, to difficulties in adjustment. From what has already been said, it is obvious that this implies a study of the bodily and mental equipment and of the behavior of the patient, and, in addition, of the social or environmental influences that may be responsible for his methods of reaction. The results of all these investigations must then be synthesized and correlated.

In addition to the psychiatrist in charge of the clinic, it is advisable to provide for technical assistants to conduct intelligence and laboratory tests, and since many problems in the various medical and surgical specialties must inevitably arise, it is especially desirable to have ready access to consultation with these other departments of dispensary service. A few beds, which will permit detailed observation of behavior under controlled conditions and permit also the performance of some of the laboratory tests, are also essential for thorough work.

But since the problems with which the clinic is concerned are essentially social, it is obvious that trained social workers to investigate conditions in the home are absolutely necessary. Such assistance, under favorable circumstances, may often be secured by coöperation with the agencies that refer patients to the clinic, but it is to be remembered that frequently success in treatment and the avoidance of more serious difficulties will depend more upon the quality of the social worker than upon any other factor.

The treatment may be considered under two headings: first, that which attempts to correct the deficiencies or faults in the patient; and, second, that which is designed to modify the conditions under which he must live. The former concerns (a) the remedying or minimizing of handicaps due to disease or defect, in which assistance is often necessary from other medical or surgical departments of a general dispensary service; and (b) the application of psychotherapy, which means the education of the patient in the nature of his difficulties and their mode of origin, with advice and assistance in adopting more satisfactory methods of meeting them. Valuable assistance in this procedure can be secured from hydrotherapy, electrotherapy, occupational therapy (used, not as a means for vocational training, but as an education in habits of application and the development of outlets for self-expression in the form of hobbies, artistic interests, etc.) and employment and recreational agencies.

In the modification of the environment, trained social workers are again essential if the patient is to be kept in the community and does not need to be removed temporarily or permanently to the simplified conditions of a hospital or colony.

In some cases it may be permissible for the clinic to secure a certain measure of legal authority over a patient which will be respected by him. This can be brought about by means of probation from juvenile, domestic-relations, or other courts or by preliminary commitment to and parole from a state hospital. Such steps, however, must be taken only with the most careful consideration, as it is absolutely essential that the patient realize that the clinic is working for and not against him. For this reason it is preferable that such steps be taken by some other agency.

The location of the clinic need not detain us; it should be as easy of access to its patients as possible and, as already pointed out, in close proximity to, preferably a part of, a general medical and surgical dispensary. The hours of operation are, however, important in view of the fact that the difficulties to be remedied are those of social adjustment. For this reason it is especially desirable to disorganize the hours of employment of the patient as little as possible. Hence evening hours should be arranged for those who cannot come during work hours.

For securing contact with patients, affiliations must be established with all organized public-welfare agencies—schools, churches, courts, police, charitable organizations, etc.—with the medical profession, and, by popular lectures and demonstrations, with the people of the community.

The source of supply of the psychiatrists to take charge of these clinics will probably vary with conditions. In large cities it may be possible to secure the services of trained neuropsychiatrists in private practice, but in many instances, especially in the smaller communities, this service should be provided by the state hospitals. The clinics serve, not only for the after-care of patients on release from the hospital, but also as a source of information concerning the history of patients before commitment and as an agency in securing early commitment where required and in preventing unnecessary commitments. In addition, the contact serves very materially to broaden the psychiatric knowledge and experience of the physician and does more than anything else to establish acquaintance and confidence between the community and the hospital.

Difficulties sometimes arise from a fear on the part of the local physicians and social agencies that the attempt to establish a clinic, with the state-hospital physician in charge, represents an effort to develop a system of state medicine. This must be met by education, and it is preferable for the initiative to come from the community. We have found that when arrangements are made for a clinic for the care of patients on parole from the hospital, it is not long before requests are received for the examination of cases referred by physicians and others. The clinic then acts purely as a consultant, leaving the actual application of the treatment to the local physician or other agency.

THE SIGNIFICANCE OF SPIRITUALISM

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SPIRITISM — or, as it is more commonly known, spiritualism—may be defined as "the belief that disembodied spirits exist and manifest themselves to men." (Baldwin) It is our purpose to attempt an inquiry into the cause or causes underlying this belief and to discuss its significance. An interesting and concise study of the subject has been recently published by Randall,[1] and in the present paper frequent reference will be made to this contribution.

Belief in life after death has existed among practically all peoples at all times, and such universality of belief has been argued as a proof of immortality—"the proof from universal consent."

A second argument for immortality may be called a psychological one, "based upon man's instinctive aspiration toward the ideal—the ideal of beauty, truth, or goodness. But since this ideal never is and never can be attained in this earthly life, therefore, there must be another life where it can be realized; otherwise man's deepest aspirations are baseless delusions and cruelest mockery."

A third or metaphysical argument for survival after death is that while the "body is composite and corruptible, the soul is simple . . . a part or fragment of Infinite Being or Universal Substance; therefore, after the terrestrial life is terminated, the soul must continue to live on, as nothing that is a part of indestructible substance can ever be lost or destroyed."

Fourth, there is a moral argument which claims that it is just that the righteous receive their reward and the guilty punishment, and that since a state of complete justice does not obtain in this life, right would not prevail unless there were some opportunity for justice to be attained hereafter.

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[1] *The New Light on Immortality or the Significance of Psychic Research.* By John Herman Randall. New York: The Macmillan Company, 1921.

Finally there are the arguments for survival after death from religion—the promises of everlasting life with God, as set forth, for example, in the Bible.

Obviously, no one or all of these arguments furnishes conclusive or final proof of life after death, although those who accept or believe them, particularly the arguments of religion, are prone to take it for granted that survival after death has been proven. There is no doubt that such arguments, leading to conviction, have given comfort and hope to countless persons.

Such convictions of immortality were undoubtedly more prevalent before the present age of science. During the last century, particularly, the spirit of scientific investigation has entered the field of religion, and the result of scientific investigation of the origin of Christianity and of the sources and development of Christian theology has been that many of the traditional beliefs have been swept away. If the leaders of religious thought had seen the light, recognizing that the old theologies were poetic mythologies containing truths that could be applied to-day to men's lives, and had not insisted rigidly on dogmas and creeds, contentment and peace of mind might have been maintained as before with the application of religion to the present age. But with the props of belief torn away and no supports from the church, there was left doubt, uncertainty, or frank disbelief in the old religion. Science was investigating facts elsewhere and undertook what was supposed to be a scientific investigation of immortality. We submit, however, that although the expressed purpose of the societies for psychical research, formed in the eighties and still in existence to-day, was and is the scientific collection of facts on the subject of psychic phenomena and manifestations of spirits, the determinant of these investigations was and is a conscious or unconscious need for survival after death, which need is the result of a dissatisfaction with or lack of completeness in the present life. This is the why of spiritualism to us. In our opinion, therefore, the acceptance of the idea of survival after death—and the belief, as indicative of this, in the psychic manifestations observed—rests rather with the emotions than with reason, and spiritualism, like religion, is a matter of faith and not of scientific fact or proof.

We may exclude from our argument those persons who by means of conscious fraud or even unconscious self-deception obtain a livelihood through the practice of spiritualism. Their need is a material one. And we think our argument as to the emotional basis of spiritualism will be readily accepted as applying to those individuals who, becoming absorbed and dominated by spiritualism, show reactions closely similar to those that we find in the psychoses and in hysteria, with the acceptance of hallucinations and apparitions as true. The desire, conscious or unconscious, to get away from difficult or intolerable reality is operative in the spiritualist as well as in the psychotic.

Likewise we may perhaps assert that there can be little question that the wish to believe that the departed survive and communicate with the living determines the acceptance of that belief by those recently bereaved through the loss of loved ones. There is a longing in such persons to remain in communication with those who were recently here, and the apparent demonstration of such communications gives solace and comfort and makes life more bearable. Those of us who have lost members of our families may have found comfort in believing that eventually we should again meet and commune with those of whom it may have been said, they "had gone to a better world." And in the heightened emotional state immediately following such losses, it might have taken much less to convince us of actual communion or communication than it would in a later period, when we had resumed our more normal or usual emotional levels and had our interests diverted by the actualities of life around us.

More doubts might arise, however, as to the validity of our arguments that belief in survival and in spiritist phenomena depends on a desire to believe, with the accompanying emotional background, when we consider the men of science who have spent much time in what they assert and believe to be exact scientific investigation, controlled by reason and not influenced by emotion. We believe, however, that even for them, our argument still holds true. One point in our favor is the fact that, with evidence identical with that on which some scientists have accepted belief in spiritualism, more or perhaps the majority of scientists, if not convinced of the falsity of the belief, are at least not convinced of its truth. We believe that the attitude of this latter unconvinced group may well be the result of more satisfaction with reality and of less need of a hereafter than is present in the "believers." Another point of interest is the difficulty of convincing the believer of fraud in the medium, as was shown, for example, in the case of Paladino. This refusal to see fraud is to our mind the result of a wish not to see it or of a wish to believe.

But let us inquire into the attitudes and motives of some of the individuals who have made so-called scientific investigations of spiritualism, to determine whether our argument holds true. At once the names of Hyslop and Lodge come to mind as outstanding figures in the field of spiritualism.

Those who knew Hyslop were in a better position than we are to determine the motives that actuated his interest and influenced his conclusions as to the truth of spiritualism. I refer to Randall for the following significant statement: "It was long ago, probably even before he came to devote himself entirely to investigation in the psychical domain, that his writings revealed plainly enough, and not involuntarily, how strong was his own inclination to believe, not only that the dead are somewhere alive, but that they can and do send messages in various forms to the living. It was this predisposition to believe that doubtless led him eventually to devote his talents exclusively to these subjects. However, it was not until late in his life that he came out frankly and publicly on the side of the spiritistic hypothesis. Before that, he carefully and somewhat laboriously maintained the attitude of a disinterested seeker after truth, of the possessor of the open mind, ready to follow wherever the facts might lead him. It was quite evident that he was fighting against his own natural desire to believe, in his desire to base his final conclusion on what he deemed to be purely scientific evidence." Whether one can maintain an open scientific attitude of mind in investigating what one wishes to believe is a question. That Hyslop's desire to believe was determined by a feeling of need of survival we may indicate by some quotations. In speaking of skepticism, he said: "It might insist on natural laws, but it was always menaced by the prospect of contending with human needs which have as much influence in determining many beliefs as any of the rigid standards of evidence.'' Again, ''There is no truth that can be made more helpful to man than a belief in survival.'' Further, ''. . . the prolongation of consciousness which is the aspiration of every effort man makes in his life.'' ''. . . if we find that nature assigns this [sensuous life] a secondary place and means to preserve the inner spiritual life for further cultivation, the sacrifice of the physical and sensuous is rendered more easy. . . .'' ''. . . . if we find that survival is a part of her [Nature's] scheme, the bitterness that would haunt us if we were without hope will be less poignant.'' ''The sadness of sunset is only sublime pathos when we are assured of another dawn.'' These fragments indicate to us that Hyslop's spiritual interests and convictions were influenced by his innermost wishes and a feeling of need of survival because of a lack of fullness and satisfaction in this life.

If it were a fact that Lodge's conviction of the truth of spiritualism had followed upon the death of his son during the war, with the son's subsequent communication, we might pass this over with the assumption that the conviction arose from a highly emotional state of bereavement such as we have previously mentioned. But he was convinced of survival and of spiritualistic manifestations before that event close to his heart took place. He had come to this conviction following psychic research, but it is interesting to note that, before he undertook such research, he was of a religious turn of mind. He was not a materialist. As Randall points out, he regarded the universe as being essentially spiritual, though manifesting itself through the material. He believed there was something more to man than his physical body; light, mind, and consciousness to him did not belong to the material world and were something quite distinct from matter and energy. It may be perhaps safely assumed, therefore, that there was the wish to believe before spiritualistic investigation was undertaken and that, like Hyslop, Lodge saw what he wanted to see, with an accentuation of the fulfillment of this wish after his son's death.

In contrast to the initial and final attitudes towards spiritualism assumed by Hyslop and Lodge are those of William

James. He felt that "immortality is one of the great spiritual needs of man" and that it has its prime roots in personal feeling, but he said: "I have to confess that my own personal feeling about immortality has never been of the keenest order and that among the problems that give my mind solicitude this one does not take the very foremost place." James is described as a nonconformist in science as well as religion. He admitted that there was something in him that was forever impelling him to search for the one "white crow" which would disprove the commonly accepted proposition that "all crows are black." "The unpopular view" had a peculiar fascination for him. It has been believed that it was his nonconformist attitude that stimulated James' interest and activity in psychic research when it was looked at askance by his friends and colleagues. In the research he evidently recognized the possibility of emotional influence on the interpretation of psychic phenomena, stating that he had expected that his verdict would be determined by "pure logic," but found that logic had played only a "preparatory part" and that the "decisive vote, if there be one, had to be cast by what I may call one's sense of dramatic probabilities." After twenty-five years' experience, James wrote, the year before his death, "I am theoretically no 'further' than I was at the beginning," and also, "I personally am as yet neither a convinced believer in parasitic demons nor a spiritualist, not an 'orthodox scientist,' but still I remain a psychic researcher waiting for more facts before concluding." Approaching the subject from a scientific, unbiased point of view, he seems to have maintained a scientific attitude and to have arrived at scientific conclusions regarding spirits. We may assume, perhaps, that there was little need in him for personal survival or for communication with the dead.

With the feeling that the truth of spiritualistic belief has not been proven and that the belief springs from a need that is not satisfied in this world, the question arises, "What had best be our attitude toward it?" Our answer is that this depends upon the individual. Just as we would not believe in trying to take away from an individual a religious belief that was a comfort to him and made life more tolerable and at the same time made him of more benefit and comfort to others, so we would not believe in trying to take away spiritualistic belief that had the same effects. Any person has a right to believe what makes him a better member of society. On the other hand, how often do we see the bad effects of spiritualistic belief—absorbing the individual, cutting him off from interest in or contact with others, making him unproductive and not only of no help to others, but a burden to them. Here the situation is different, and certainly it is incumbent upon us to attempt to direct such unhealthy activities into more productive channels. The possibility of redirection in such persons obviously depends upon the strength of the wish to believe, the depth of fixation of the belief, the ability to obtain new outlets, and possibly the personality of the redirector.

I imagine that many of us are not deeply concerned from day to day with the question of our own survival after death or with the question of whether or not the dead can or do communicate with us, and I take it that this is because we are more concerned with the life of reality about us, in our contact with other persons, with our aim to help to make life happier and more complete for those with whom we come in contact, and that in so doing we are deriving a satisfaction and happiness ourselves that leaves little if any feeling of need for a more attractive world beyond. There is so much around us to be done that we seldom raise our eyes from this earth and gaze longingly toward that infinite heaven which to the spiritualists and to many others is the only place where there is an opportunity to live out one's destiny in completeness. Although all is not joy and happiness here, I take it that we are trying and striving to make this earth a better place to live in and thereby fill our lives still more completely. If only the individuals with eyes and ears so intent upon another world could bring their eyes back to earth and live in reality, they would very likely find that the world here and now, in which they seem to find only misery and unhappiness, is not such a bad place after all.

LAWS CONTROLLING COMMITMENTS TO STATE HOSPITALS FOR MENTAL DISEASES*

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LEGISLATION relating to the hospital care of mental diseases has for many years been based almost entirely on the assumption that the only question at issue was the protection of the community from the so-called insane. Very little consideration has been given by the framers of our laws to the welfare of the patient. The word insanity itself is a purely legal and not in any sense a medical conception. It may be said to relate to mental diseases only in so far as they come within the jurisdiction of a court. Nor have those who have been responsible for the use of this term in our legislative enactments any clear conception as to its meaning. It has usually been used synonymously with lunacy, a word that was written into the laws of England in 1320 in the reign of Edward the Second and appears there to-day. Von Feuchtersleben, who wrote a surprisingly progressive treatise on mental diseases in 1845, was unwilling to go on record positively as saying that the moon has no influence on the human mind.

A reference to the Massachusetts and New York statutes of the present time will show what progress has been made in our legal nomenclature since that time. Mental diseases are referred to in the Consolidated Laws of New York in terms of lunacy, and defined as including every kind of unsoundness of mind except idiocy. (Section 28, Chapter 27, Consolidated Laws of New York.) The Revised Laws of Massachusetts specify to-day that "the words 'insane person' and 'lunatic' shall include every idiot, non compos, lunatic and insane and distracted person." (Section 5, Chapter 8, Definition 6, Revised Laws of Massachusetts.)

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* Read at a meeting of the Mental Hygiene Section of the Rhode Island Conference on Public Welfare, Providence, December 9, 1920.

The use of such words as lunatic, lunacy, asylum, alienist, et cetera, is limited now very largely to the court room and the newspapers. More modern legislation relating to the forms of mental disease that render the individual subject to legal custody is illustrated by the Civil Code of Illinois. This defines an insane person as one "who by reason of unsoundness of mind is incapable of managing his own estate, or is dangerous to himself or others, if permitted to go at large, or is in such condition of mind or body as to be a fit subject for care or treatment in a hospital or asylum for the insane." A person is legally insane in Alabama "who has been found by a proper court deficient or defective mentally, so that for his own or others' welfare his removal is required for restraint, care, and treatment." The interest of the law in mental disease may, therefore, be described as one of either personal or property responsibility. The more important question of criminal responsibility is one that is too comprehensive for proper consideration at this time.

The necessity of some form of legal commitment to hospitals for mental diseases is based on the fundamental principle in English law that no man can be deprived of his liberty without due process of law. This right was clearly recognized in the Magna Charta granted the English people by King John in 1215 and is specifically mentioned in at least two different articles in the Constitution of the United States—Article V and Article XIV. The established form of procedure which is now generally followed in all parts of this country includes (1) an application for commitment to an institution, (2) the medical certificate of two or more duly qualified physicians, showing that the person whose commitment is petitioned for is insane within the meaning of the law and is a proper subject for care and treatment in an institution, and (3) the order of a court of record for commitment to a state or private hospital.

In some states the petition may be made only by certain persons specified in the law, usually the parents, relatives, guardian, or friend, or certain public officials. In some states any person may make the application. In Florida the application must be signed by five reputable citizens. This does not seem to be a material point in law. Some courts insist that a notice of such an application must be personally served upon the person whose commitment is asked for in the petition. In New York such a notice must be served at least one day prior to the hearing of the case unless the judge shall show in a certificate some adequate reason why personal service has been dispensed with, or that substituted service was made upon some other person designated by him. This is a wise precaution in view of the fact that the constitutionality of commitments without personal service has been questioned. The medical examiners are usually required to be graduates of a reputable medical school and licensed practitioners in medicine, with not less than three years' practical experience. On the filing of an application for commitment, a warrant of arrest is issued in some states and various forms of temporary detention provided for. This would not appear to be necessary in most instances. It should at least be discretionary with the court. The court may or may not allow the alleged insane person a hearing. This is usually, and should be, discretionary with the judge, unless a formal demand for a hearing is made. When this is done, notice of such a proceeding is usually served upon all persons immediately concerned. Formal hearings are required in all cases, the alleged insane person being present, in a number of states. Usually the question as to the presence of the patient is left to the court. Obviously it is often impossible. Trial by jury is often discretionary with the court, or may be granted on demand, and is required in all cases in Georgia, Kentucky, and Wyoming. There would appear to be no reason why a jury trial should be necessary or even advisable in any other than criminal cases. A determination of the mental condition of the alleged insane person is often made by a referee or a commission appointed by the court at its discretion. Nebraska, New Jersey, Iowa, North Dakota, and South Dakota have commissions in lunacy in each county. Practically every state has made provision for appeal from the decision of the court in matters of commitment.

When an insane person has been committed to an institution, it is usually the duty of the sheriff or some other court officer to remove the patient to the hospital. The order of the court in Massachusetts includes the following: "NOW, THEREFORE, You, the said Sheriff, Deputies, Constables or Police Officers, and each of you, with necessary assistance, ..., are hereby commanded, in the name of the Commonwealth of Massachusetts, forthwith to convey the said .... to the hospital .... aforesaid, and to deliver h.... to the Superintendent thereof, and make due return of a copy of this precept with your doings therein.'' This makes the removal of the patient to the hospital to all intents and purposes practically the same as in a criminal proceeding.

Attention should be called to one of the very excellent and humane provisions of the New York law: ''All county superintendents of the poor, overseers of the poor, health officers and other city, town, or county authorities, having duties to perform relating to the poor, are charged with the duty of seeing that all poor and indigent insane persons within their respective municipalities are timely granted the necessary relief conferred by this chapter. The poor officers or authorities above specified, except in the city of New York and in the county of Albany, shall notify the health officer of the town, city, or village of any poor or indigent insane or apparently insane person within such municipality whom they know to be in need of the relief conferred by this chapter. When so notified, or when otherwise informed of such fact, the health officer of the city, town, or village, except in the city of New York and the county of Albany, where such insane or apparently insane person may be, shall see that proceedings are taken for the determination of his mental condition and for his commitment to a state hospital. Such health officer may direct the proper poor officer to make an application for such commitment, and, if a qualified medical examiner, may join in making the required certificate of lunacy. When so directed by such health officer, it shall be the duty of the said poor officer to make such application for commitment. When notified or informed of any poor or indigent insane or apparently insane person in need of the relief conferred by this chapter, such health officer shall provide for the proper care, treatment, and nursing of such person, as provided by law and the rules of the commission, pending the determination of his mental condition and his commitment and until the delivery of such insane person to the attendant sent to bring him to the state hospital as provided in this chapter."

In New York City these responsibilities are delegated to the trustees of Bellevue and allied hospitals and in the county of Albany to the Commission of Public Charities. In New York City a nurse or medical examiner—or both—from the psychopathic wards of Bellevue Hospital is sent "to the place where the alleged insane person resides or is to be found." If in the judgment of this examiner medical care is necessary, the patient is taken to the psychopathic ward for observation for a period not to exceed ten days. When a patient has been committed to a state hospital in New York, the superintendent is required by law to send a trained nurse or attendant to bring the patient to the institution. The advisability of having such cases under the immediate care of trained nurses who have had an adequate psychiatric training should receive the serious consideration of all authorities charged with the commitment of persons to hospitals for mental diseases. There is no reason why persons suffering from mental diseases should be subjected to the same form of supervision that is given to criminals. The New York plan of holding the health officer responsible for providing proper hospital care and treatment for mental cases that do not come directly under the legal jurisdiction of other persons or officials is worthy of consideration and should be adapted to the needs of other communities. There would appear to be no reason why the health officer should not logically be responsible for mental conditions in somewhat the same way that he is for communicable diseases. To what public official can the supervision of the insane pending commitment more properly be entrusted?

In twenty-nine states provision has been made for the reception of voluntary patients in state and private hospitals. The law usually provides that the patient must sign an application for admission, that his mental condition must be such that he can understand the nature of this request as well as the need of treatment, and that he must be released on a demand in writing in from three to seven days of such application. In the case of six of these states his request for admission must be accompanied by the certificate of one or two physicians, and in some instances his application must be signed in the presence of a physician.

Fifteen states and the District of Columbia have laws authorizing commitment for temporary care and observation. They are Connecticut, Illinois, Maine, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Washington, and Wisconsin. Massachusetts has the most elaborate system for temporary care and observation, as is shown by the following provisions:

The superintendent of a state hospital may receive and detain, for not more than five days without a court order, any person whose case is "certified to be one of violent and dangerous insanity or of other emergency" by two qualified medical examiners. Officers authorized to serve a criminal process, or police officers, must, on the request of the applicant or one of the examining physicians, bring such a person to the hospital. (Section 42, Chapter 504, Acts of 1909.) The applicant for this form of admission must within five days arrange for the commitment of the person so received, or for his removal from the hospital.

Under another provision of the Massachusetts law, a person found by two qualified examiners to be in such mental condition that his commitment to a hospital for the insane is necessary for his proper care or observation may be committed to a state hospital "for a period of thirty-five days pending the determination of his insanity." (Chapter 145, Acts of 1919.)

Under the provisions of the so-called "Boston Police Act" (Chapter 307, Acts of 1910), all persons suffering from delirium, mania, mental confusion, delusions or hallucinations, under arrest or "who come under the care or protection of the police of the city of Boston" shall be taken to the Boston Psychopathic Hospital "in the same manner in which persons afflicted with other diseases are taken to a general hospital." Cases suffering from delirium tremens or drunkenness may be refused by the hospital authorities; otherwise, all such persons are admitted, observed, and cared for "until they can be committed or admitted to the hospital or institution appropriate in each particular case'' unless the patient recovers or is discharged.

Under the provisions of Chapter 394 of the Acts of 1911 (Massachusetts), ''no person suffering from insanity, mental derangement, deliriums or mental confusion, except delirium tremens or drunkenness, shall, except in case of emergency, be placed or detained in a lockup, police station, city prison, house of detention, jail, or other penal institution or place for the detention of criminals. If, in case of emergency, any such person is so placed or detained, he shall forthwith be examined by a physician and shall be furnished suitable medical care and nursing and shall not be so detained for more than twelve hours.'' In Boston these cases are sent to the Psychopathic Hospital. In other parts of the state they are cared for by the board of health of the city or town in question until they can be committed to a state hospital or cared for by relatives or friends.

The superintendent of a state hospital, under the authority of Chapter 174 of the Acts of 1915, ''when requested by a physician, by a member of the board of health or a police officer of a city or town, by an agent of the institutions-registration department of the city of Boston, or by a member of the district police 'may' receive and care for in such hospital as a patient, for a period not exceeding ten days, any person who needs immediate care and treatment because of mental derangement other than delirium tremens or drunkenness.'' Such admissions are received on application in writing filed at the time of the reception of the patient or within twenty-four hours thereafter, and must be discharged or committed within ten days unless they make a request for voluntary care.

It may be interesting to note that the temporary-care enactments have very largely determined the legal status of the cases admitted to the Boston Psychopathic Hospital. During a period of six years, 6,499 cases, 57.5 per cent of all admissions, were committed under the ''ten-day'' temporary-care act referred to. Nine thousand and seventy-four, or 80.3 per cent, of the total number of admissions during the same period were temporary-care cases of one kind or another. The relative importance numerically of the temporary-care group as compared with the voluntary cases is shown by the fact that the latter constituted 17.6 per cent of 11,289 admissions. It has been customary to limit the hospital residence of temporary-care cases to ten days or less. This has been a purely arbitrary arrangement. At the State Psychopathic Hospital at the University of Michigan, where there have been no time limitations on residence, an analysis of 1,279 admissions shows that 74 per cent of the cases were discharged within three months. Approximately 10 per cent were discharged within two weeks. This would strongly indicate the advisability of extending the period of temporary care to at least thirty days.

The provision of the Massachusetts law for the determination of the mental condition of persons under arrest or held under criminal charges is an excellent one and well worthy of consideration. This is covered by Chapter 46 of the Acts of 1917: "If a person under complaint or indictment for any crime is, at the time appointed for trial or sentence, or at any time prior thereto, found by the court to be insane or in such mental condition that his commitment to a hospital for the insane is necessary for the proper care or observation of such person pending the determination of his insanity, the court may commit him to a state hospital for the insane under such limitations as it may order." The court may in its discretion employ one or more experts to examine such persons. These cases are on recovery returned by the hospital authorities to the custody of the court. One of the interesting features of the Massachusetts law is the provision relating to persons indicted for murder or manslaughter, but acquitted by a jury by reason of insanity. Such cases are committed to a state hospital for life and can be discharged only by the governor of the state with the advice and consent of the executive council, when he is satisfied, after an investigation by the Commission on Mental Diseases, that such a person may be discharged "without danger to others." (Section 104, Chapter 504, Acts of 1909.)

In 1919 the National Committee for Mental Hygiene made an extended study of methods of commitment to institutions for mental diseases. A comprehensive report on this subject was made by a committee consisting of Dr. George M. Kline, Commissioner, Massachusetts State Department of Mental Diseases; Dr. Charles W. Pilgrim, Chairman of the New York State Hospital Commission; Dr. Owen Copp, Superintendent, Pennsylvania Hospital, Department for Nervous and Mental Diseases; Dr. Frank P. Norbury, of the Board of Public Welfare Commissioners of Illinois; and Dr. Frankwood E. Williams, of the National Committee for Mental Hygiene. In addition to the regular commitments by a court of record in a civil proceeding, they recommended legislation in all states authorizing temporary care, emergency care, observation pending the determination of insanity, and voluntary admissions. In a general way, the legislation proposed was modeled after that of Massachusetts.

THE STATE PSYCHOPATHIC HOSPITAL*

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IN spite of the general interest that has been shown in the subject of psychopathic hospitals by those who are concerned with the care of the mentally disordered, the establishment of this type of institution has progressed but slowly. The experiences of the few hospitals of this type that are already in existence have definitely shown that they have a field of work in which they are accomplishing great good, and that they have developed machinery for meeting aspects of mental disorders in ways not otherwise provided.

Discussions that have centered about the establishment of these hospitals have brought out some differences of opinion as to the type of organization that was desirable and the field of work with which they were to be concerned. In a large measure these differences have had their source in the feelings of necessity to adapt the new organization to local situations, this seeming to be the most practical way to bring about public support. It has, however, usually been appreciated that compromises were being made with the conception of the ideal institution. Thus, there are now in existence psychopathic hospitals, state psychopathic hospitals, psychopathic wards of general hospitals, psychiatric clinics, and psychiatric institutes.

All of these have their distinct values and are meeting their problems in a more or less adequate manner, but the idea must be kept clearly in mind that they are not all equivalent.

The psychopathic hospital, whatever be its title, implies an institution of a definite type of organization and special facilities. As formulated by Dr. Southard in one of his reports, "it is an institution ready to attack within its means all the problems of psychopathology, both practical and theoretical, having in mind the patient of the day and the patient of the future."

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*Reprinted through the courtesy of the *American Journal of Insanity.*

A conception such as this can be realized only by an organization having its own special building for the observation and treatment of a limited number of patients. It must be administered by a medical staff of adequate size, specially qualified for psychiatric work. It should have ample laboratory facilities for research and clinical diagnosis, and above all its activities should be dominated by an attitude of keen scientific interest.

Different problems of situation will in a general way determine two types of psychopathic hospitals—one that must adapt itself to the problems of mental disorders as they concern the state as a whole, or the state psychopathic hospital, and one that must adapt itself to the psychiatric problems of a concentrated district, or the municipal psychopathic hospital.

The circumstance that the care of the mentally disordered has always been a problem largely assumed by the state has naturally directed most interest to the state type of hospital. But the field of work that will serve the purposes of the state as a whole will not meet the psychiatric problems that exist in every densely populated community. The density of population, with its complicated social situations, the character of problems that are presented to organizations doing welfare work, those that arise in the schools, and especially in the courts dealing with crime and delinquencies, these and many other problems that have become apparent in the larger cities during recent years require a special type of institution to carry on adequately the functions of a municipal psychopathic hospital.

It is our purpose on this occasion to discuss the organization and activities of the type of institution that in our opinion would best serve the needs of the state as a whole, adapting its field of work to the existing organizations of the state that are now caring for the insane and mentally disordered.

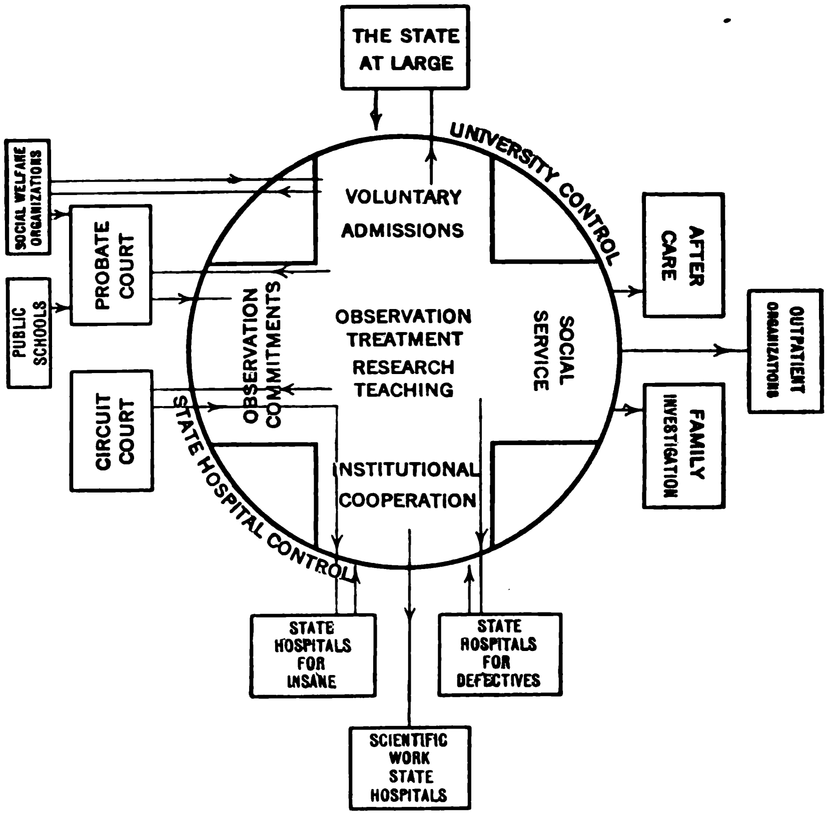
At the present time perhaps the most urgent motive for the development of psychopathic hospitals is to serve as teaching centers for psychiatric training. This bears directly on the problem of the location of the hospital. Psychiatric teaching can be best carried on in as intimate connection with a medical school as possible. Where the state has a state university and in connection with this a medical school, this obviously should determine its location. While psychiatry should always be regarded as a branch of medicine, there are aspects of the subject that may be taught with much success in connection with the undergraduate courses of a university. Where the state university has no medical school, a psychiatric hospital would still find a most useful place in close relation to the university. Where there is no state university, its location might be determined by the size of a community, proximity to general hospitals or district hospitals for mental disorders, or by special facilities peculiar to state situations.

The administrative control would in a large measure depend upon the system followed by a state in the administration of its district hospitals for mental disorders. The management might equally well be cared for by central boards of administration or by boards of trustees. Where the psychopathic hospital is in intimate relation with a university, there is much advantage in having the governing board of the university or medical school represented on the administrative board of the hospital. Such an arrangement as this works most satisfactorily in the administration of the State Psychopathic Hospital at the University of Michigan. This hospital is under the control of a board of eight trustees, four of whom are chosen from among the trustees of the state hospitals for the insane and four from the board of regents of the university. By this joint administration the interests of the hospital both in its relation to university teaching and to the state organization caring for the mentally disordered may receive careful consideration.

In the plate accompanying this paper I have represented in diagram the organization of a state psychopathic hospital, its relations to the care of patients, and its field of work.

For purposes of discussion, the fundamental activities of the hospital are subdivided among (1) observation, (2) treatment, (3) research, (4) teaching. All of these intimately interlock and all center in the patient. While local circumstances—such as special relations with courts and welfare organizations, relations to general hospitals and medical schools, special types of clinical material, special laboratory opportunities, or a personnel unusually qualified for special problems—may stress more particularly one of these fundamental divisions of the hospital's interests, it is our personal belief that the state will be rendered best service when these interests are balanced as equally as possible.

STATE PYSCHOPATHIC HOSPITAL


THE STATE AT LARGE
UNIVERSITY CONTROL
SOCIAL WELFARE ORGANIZATIONS
PROBATE COURT
PUBLIC SCHOOLS
CIRCUIT COURT
VOLUNTARY ADMISSIONS
OBSERVATION COMMITMENTS
OBSERVATION
TREATMENT
RESEARCH
TEACHING
SOCIAL SERVICE
INSTITUTIONAL COOPERATION
STATE HOSPITAL CONTROL
AFTER CARE
OUTPATIENT ORGANIZATIONS
FAMILY INVESTIGATION
STATE HOSPITALS FOR INSANE
STATE HOSPITALS FOR DEFECTIVES
SCIENTIFIC WORK STATE HOSPITALS

One advantage that the psychopathic hospital should have that cannot well be a feature of a district hospital of a state is a degree of flexibility of operation that will allow it to take up special psychiatric problems that may arise at any moment. New avenues for extension of the interest of the hospital will be continually opening up, and the hospital should be ready and easily adjustable to meet any of these.

For carrying on these fundamental activities, the hospital should be provided with all necessary facilities: Its laboratories, treatment facilities, teaching rooms, apparatus, and libraries should be adequately equipped and maintained. Unless this is done, the hospital will lack the distinctive features that are one of the chief reasons for its establishment.

The essential purposes of a special hospital for intensive observation and treatment must necessarily limit its capacity. The exact number of beds that the hospital should have is a matter of detail, but the number should be small enough to permit a thorough observation and intensive study of its patients. Its size should be determined by the number of physicians it is practical to maintain on its staff. It is not practical to adjust its size to the demands for admission of patients. These, if the hospital attains success and holds the confidence of the people, will far exceed the ability of a hospital of moderate capacity to care for. It should be sufficiently large to furnish varied clinical material for teaching and to maintain the clinical interests of the staff. According to the size of budget that a state might allow for maintaining a medical staff, its capacity should not be less than fifty beds nor should it much exceed one hundred. The State Psychopathic Hospital at the University of Michigan, with a clinical staff of four full-time physicians, has a capacity of sixty-two beds in which are annually treated about three hundred and twenty-five patients. The smaller the number of beds and the larger the clinical staff, the more do the patients benefit and the more opportunity will be available for research.

The psychopathic hospital is essentially a diagnostic hospital. It should be a hospital in which every facility of proven value should be available for diagnostic aid. As a treatment hospital, its functions must unfortunately be limited, owing to the prolonged course that is usual in severe mental disorders. The length of time required for cure or marked improvement of the psychoses is a matter usually of months and even years. To assume a prolonged treatment of patients and at the same time have a space available to receive all patients that are specifically suitable for a hospital of this type would require a number of beds so large that it would be difficult to manage without a clinical staff of impractical size. Of the patients at Ann Arbor who recover under treatment in the hospital, 84 per cent recover within three months and 69 per cent of all patients discharged have been in the hospital less than three months.

The limited capacity and special purposes of a psychopathic hospital demand that some selection should be exercised in the type of mental disorders that are to be admitted for examination and treatment.

While the hospital might be of great service to the state if it might act as a clearing house to which all mentally disordered patients who require treatment should be sent for examination, such a plan seems impractical owing to difficulties of transportation and the large number of patients that would require care. There are certain types of mental disorders that the psychopathic hospital is peculiarly suited to care for, and for which the state now makes inadequate provision. These are individuals who are mentally ill, but not to a degree or character to enter the district hospitals of the state. The larger number of such patients are ill with psychoneuroses or are suffering from pathological mental difficulties which interfere with their success in life, but do not require the legal restrictions that commitment to a hospital for the insane necessitates. Such patients come to the attention of physicians, school officers, social workers, general hospitals, and from families who appreciate their mental illness, but hesitate in sending the patient to a hospital for the insane.

There are some special types of definite insane conditions that the psychopathic hospital should receive for diagnosis and treatment. These are patients with mental disorders directly interrelated with physical disease. Disorders such as these require unusual skill and facilities for diagnosis. Their treatment is so largely medical or surgical that they should have the advantages of the special facilities available where a hospital is intimately a part of a general hospital or medical school.

In practice it has been found difficult to limit the admissions to any particular class of patients. When a state hospital offers unusual facilities for examination and treatment, it is but natural that there should be a large demand by citizens of the state for the admission of those in whom they are personally interested, no matter how unsuitable they may be for treatment in this special type of hospital. As the committing authorities become familiar with the purposes of the hospital, this difficulty will be minimized. There are also advantages in having available a wide range of types of mental disorders for purposes of research and teaching.

The problem of the types of patients that are to be admitted will in a large measure be determined by the points of contact that the hospital establishes with organizations of the state that come into direct relation with individuals with mental difficulties. As a diagnostic hospital, it should as far as possible coöperate intimately with the schools, courts, state institutions, and welfare organizations of the state. It should be possible for these agencies to send to the psychopathic hospital for diagnosis individuals who seem to have mental disorders that may be related to their backwardness and delinquency or social maladjustment. The results of this observation should aid in a proper medical or social treatment.

The legal provisions governing the admission of patients to the hospital should be as free as possible from formalities that may in any way produce social embarrassment for the patient. While undoubtedly legal restraint of some sort is necessary for those who need treatment and yet are unwilling to enter the hospital, or for those who may be a social menace if at large, the aim should be to arrange the conditions for admission so that they may approach as nearly as possible to those in practice for the admission of patients to general hospitals. During the past year 53 per cent of the admissions to the State Psychopathic Hospital at the University of Michigan were voluntary and of these 43 per cent were supported at public expense.

An important field of work for the state psychopathic hospital should be in connection with criminal and juvenile courts. In this they would be of great service in the determination of mental disorders in those accused of crime or delinquency. The extent to which a psychiatric hospital can extend its service into the field of criminology is at present much hampered by formalities and limitations that surround the administration of the criminal law. There is no more rational approach to the problems that concern the criminal courts than by study of the personality of the individuals they deal with. The needed information can be obtained only by the psychiatric examination. While there are serious difficulties in caring for criminal cases among the general group of patients of a psychopathic hospital, this need not prevent the institution from in some way developing a close coöperation with the courts.

The highly qualified personnel of the medical staff of the psychopathic hospital and its laboratory facilities should place the psychopathic hospital in the position of a state institute for psychiatry. As such, it should have an intimate coöperation with the district state hospitals caring for patients with mental disorders, not only hospitals for the insane, but those for the epileptic and defective. It should be possible for these hospitals to transfer to the state psychopathic hospital such patients as may be expected to benefit by the diagnostic and treatment facilities of that hospital. This coöperation will be needed by reason of the necessity of transferring patients from the psychopathic hospital to these hospitals after a period of observation and treatment. The double interest thus established in the patient would be a helpful means of maintaining this coöperation. About 22 per cent of the patients discharged from the State Psychopathic Hospital at the University of Michigan are transferred directly to a district state hospital and an additional small per cent enter these hospitals after a period at home.

As a central institute coöperating with other state hospitals, there are possibilities of conducting research activities in a most favorable way. In the work of the pathological laboratories, material for study could be furnished by the state hospitals, and the results of this study should be systematically communicated to the respective state hospitals. Such a plan will keep the medical interests of all hospitals at a high standard. Its central relation to the state hospitals caring for the mentally disordered would provide the state with a most useful organization for determining policies dealing with mental disorders and of conducting a unified attack upon these serious problems as they affect the public health.

The laboratories of the hospital could assume diagnostic work not possible in the separate district hospitals. By doing the serological work for these state hospitals it could most effectively unite the interests of all in problems as they affect the state as a whole.

The facilities of the psychopathic hospital should at all times be at the disposal of the state hospitals for mental disorders. For purposes of study, classes for systematic intruction in psychiatry should be arranged for the benefit of the medical assistants of the state hospitals.

This centralizing of laboratory functions need not interfere with the independence of action of the large state hospitals, nor should it limit the field of interests of these institutions. This has not occurred in Michigan, where the psychopathic hospital has at all times had the most cordial coöperation from the other state hospitals.

A most important division of the activities of a psychopathic hospital is one that should be concerned with the social aspects of psychiatric problems. Mental disorders are so frequently interlocked with personal situations of environment, of family and occupational relationships, that the hospital will fall short of its possibilities for the treatment of patients unless it is prepared to deal with these problems. These include both intra- and extramural interests. The intramural social psychiatric work involves studying the social relations of the patient in respect to family, school, and occupational life. Unless this information is available, it is not possible to give adequate treatment to a large proportion of patients seeking aid from the hospital. In this feature of the work of the hospital it is desirable that there be an intimate coöperation between the medical staff and those who are technically trained in psychiatric social work. While the attitude of the hospital toward the patient should always be dominated and directed by a medical point of view, there are some aspects of treatment that can be well cared for by lay workers who are specially trained in the problems of social influences upon personality. If this is recognized by the hospital and adequately provided for, the clinical work will be greatly facilitated.

The interdependence of social relations with problems of mental health forces upon the hospital the necessity of assuming extramural responsibilities. As a state hospital having the entire state as its field of work, the possibilities for extramural work and social psychiatric service are almost unlimited. The fundamental purpose in the organization of this work should be to extend as far as possible facilities for psychiatric diagnosis and treatment to the citizens of the state. In details and plans of operation this extramural work must be somewhat different from those of the psychopathic hospital of a municipality. This is largely due to the widely scattered and often far distant localities from which patients come to the hospital and to the lack of development of social welfare organizations in the smaller communities.

The hospital should maintain out-patient clinics, traveling field services, and should carry on family investigations that concern the patients they examine and treat. The development of the extramural work at the State Psychopathic Hospital at the University of Michigan has been one of its most useful features. In its local out-patient service in connection with the general hospital of the university, it annually examines over 600 patients, and in its out-patient service in Detroit over 1,200 patients are annually cared for. Plans for future developments include the organization of a traveling psychiatric clinical service that will enable the hospital to extend its facilities to most of the towns and communities of the state.

Not only should the state psychopathic hospital be interested in what directly bears on the treatment of its patients, but its position and facilities should make it the leader in the state in the field of mental hygiene and a force for educating the public regarding whatever is active in impairing the mental health of the citizens of the state. It should be the psychiatric division of the public-health agencies of the state.

The conception of the organization and function of the state psychopathic hospital that we have developed in this discussion is something more than that of a hospital for treatment, research, and teaching in their more restricted meaning. It is that of a state agency to deal with psychiatric problems in their widest relations to the health of the citizens of the state. Its possibilities for practical services will be limited only by the ability of its administrative personnel and the financial support given to it by the state. It is a new unit of the states' system for caring for the mentally disordered, supplementing the functions of the present state hospitals for the insane and able to coördinate all of the psychiatric activities of the state.

It is to be hoped that there may be a more general recognition of the need of such institutions throughout the country.

A STUDY OF THE ECONOMIC STATUS OF FORTY-ONE PARETIC PATIENTS AND THEIR FAMILIES*

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EXPERIENCE has shown us that the main social difficulties in which the families of patients with general paresis are involved are of an economic nature. The inefficiency, irritability, and peculiarities of the paretic patient often lead to loss of work and to hospitalization. A reshaping of the home and a change in the social and financial arrangements are thus demanded. It seemed worth while to study intensively a group of paretic patients in order to determine just what the social worker and the doctor can expect to encounter in the way of social maladjustments caused by or coördinate with general paresis.

As our interest was in the family, a group was selected along the following lines: Only committed male patients with general paresis, between the ages of twenty and fifty, who were married and had children, were considered. Male committed patients were chosen because we were interested in noting the social effect of syphilis in families from which the main support was withdrawn. The age period represents the best years of a man's life, before which one would not expect him to carry much responsibility and after which his powers might decline without the agency of syphilis. Obviously, the problems of the unmarried are different. Families without children were not included nor those in which the wife was dead, as we wished to study families that were complete except for the committed member. Patients whose families lived out of reach were not studied, as no reliable data could be secured. All inquiries were made by reading of records supplemented by home visits to the nearest relative. In 33 of the 41 families, it was possible to interview the wife and secure first-hand information. In the remaining cases, near relatives were interviewed and their stories were supplemented by the history already given in the records.

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* This study was carried on by funds from the Interdepartmental Social Hygiene Board. We wish to express our appreciation to Mrs. Gerna S. Walker for her assistance in the field work and tabulation.

The main points investigated were:

1. The industrial status of the patient in relation to his disease, emphasizing comparative earnings, types of position, capacity for accomplishment, etc., before and at the acute onset of the disease.
2. The effect of the patient's illness on the wife in the home.
3. The effect on the children.
4. The necessity for familial financial aid.

Let us take up these points one by one.

An examination of the annual earnings of the 41 paretic patients studied shows that we are not dealing with a group normally below the poverty line. Thirty patients were earning over $900 annually for the five years directly preceding the investigation (1914–1919), as shown by the following summary:

Annual earnings *	*Patients*
Under $625	4
$625-$899	5
$900 and over	30
Unknown	2
Total	41

At the time of admission and commitment to a state hospital, when their salaries automatically ceased and new means of support for the family had to be created, 22 patients were still receiving their normal salaries, 9 were at a minimum salary, and 7 at a maximum. Of the 7 cases of maximum salary on admission, 6 were due to inflated war wages and in the seventh case the patient's salary was deliberately increased so that on retirement he could receive a larger pension. This war increase indicates the scarcity of labor, without which probably more patients would have been reduced in salary. The fact that the salaries of the majority were unchanged does not mean that their work remained high grade. The cause might be labor conditions such as those just mentioned, length of time in the job, kindness of employers, etc. As a matter of fact, further study shows a decided decline in capacity.

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* This summary gives wage earned by patient five years before investigation was made. The grouping of annual earnings follows a similar grouping in a study of infant mortality in Johnstown, Pa., made by the Children's Bureau, 1915.

It was possible to obtain information on the ways in which the decline in capacity manifested itself in 27 of the 41 patients. Such descriptive terms of decline were used by relatives as "inefficient," "unreliable," "could not concentrate," "slow," "childish," "tired and took much time off," "irritable and unreasonable," "could not use hands well." It is evident that there is a general mental deterioration manifesting itself in slowness and inefficiency. This decline was slow and insidious in some cases, acute in others. The following summary shows that the decline of the 27 varies from a month to two years and over:

Length of decline	*Patients*
Under 1 month	1
1 to 6 months	7
6 months to 1 year	5
1 to 2 years	5
2 years and over	3
"Few months"	2
"Months"	1
Unknown	3
Total	27

One naturally questions whether these men were thrown out of work because of this inefficiency, whether they changed jobs frequently, or how their economic status was affected. We found that 13 of the 27 had worked for the same firm five years, and an additional 2 for several years before admission, and were kept on because of faithful service. Two patients were in business for themselves and as a result of their incapacity failed. Four had not been in any one's employ for a long period, as they normally changed jobs frequently.

In addition to the above mentioned incapacity, irregularity at work might be a sign of deterioration. Seven of the 41 patients were extremely irregular at work for "a few months to two years" before admission. An additional 12 had held "many" jobs during the five years before admission. Thus we have a total of 19, or almost one-half, who were irregular at work.

Jobs held during last five years	*Patients*
One	18
Two	6*
Three	2
Four	2
Five	..
Six	1
Unascertained	12
Total	41

The 12 unascertained cases had held many jobs. In 9 of the 12 the frequent change was ascribed to the instability, unreliability, and inefficiency of the patient. It must, however, be kept in mind that many of the patients showed considerable stability. Only 8 of the 41 changed their *type* of work during these five years, 6 to less skilled work and 2 to different work on the same plane. As shown above, 18 had worked for the same firm for the five years previous to hospital admission, and an additional 8 had had two or three jobs. Thus 26 were steady on the job, while 15 had had several jobs. This is shown again by the following outline with emphasis on the length of time in the last job:

Length of time in last job	*Patients*
Under 6 months	8
6 months to 1 year	3
1 to 2 years	3
2 to 3 years	1
3 to 4 years	2
4 to 5 years	2
5 years and over	18
Unknown	4
Total	41

The reasons given for leaving the last job are of interest. Over one-half gave a medical cause. The others could not keep up in their jobs, and this was recognized by employers and family. The following summary gives in detail the causes assigned for the 41 patients leaving their last job:

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* One patient who held two jobs held them both at the same time, one during the day and one in the evening.

Medical cause	*Patients*	*Industrial cause*	*Patients*
Sick	8	Work became poor	4
"An attack"	2	Inefficient	3
Physical incapacity	2	Lack of attention to duties	2
Hands unsteady	2	Accounts confused	1
"Tired and run down"	4	Making mistakes	2
Worried and nervous	1	Forgetful	1
Loss of leg in accident	1	Discouraged	1
Drink	1	Extravagant ideas and plans	1
Shock	2	Delusions concerning fellow workmen	1
Unknown	2		
Total	25	Total	16

The time out of work before admission is of importance in relation to the economic status of the family of the patient with general paresis.

Time out of work before admission	*Patients*
No time	6
Under 1 month	15
1 to 6 months	13
6 months to 1 year	3
1 year and over	2
Unknown	2
Total	41

This summary shows that the large majority, though often inefficient at work for a long period, as shown on page 558, were actually out of work only from a few days to six months. This, together with the small decline in wages, would indicate that although actually the patient has been an increasingly incapable person, the income of the family is not usually markedly diminished for a long period before commitment. The family was usually able to get along during these months, but the seriousness of the strain is felt when the savings are eaten up simultaneously with the commitment of the wage earner. Something must then be done at once to replenish the family finances.

This brings us to our second point, the effect of the patient's commitment on the wife. Eighteen of the wives went to work because of the patient's illness—12 full time and 6 part time, 14 outside the home and 4 at home. Those working outside the home did work varying from washing, ironing, and cleaning to factory and office jobs. Those who remained at home earned their living by sewing or taking lodgers and boarders.

The wages earned by these wives are shown in the following summary:

Part time	*Wives*
$2 a week	1
$7.50 a week	1
$8 a week	1
$10 a week	1
$12 a week	1
$14 a week	1
Total	6

Full time	*Wives*
$12 a week	1
$13 a week	2
$13.50 a week	1
$15 a week	2
$16 a week	2
$18 a week	2
$21 a week	1
$35 a month with keep for self and child	1
Total	12

Outside home	*Wives*
$2 a week	1
$7.50 a week	1
$8 a week	1
$10 a week	1
$12 a week	2
$13 a week	1
$13.50 a week	1
$15 a week	1
$16 a week	1
$18 a week	2
$21 a week	1
$35 a month with keep for self and child	1
Total	14

At home	*Wives*
$13 a week	1
$14 a week	1
$15 a week	1
$16 a week	1
Total	4

In addition to the fact that these 18 wives had to undertake the burden of aiding in the support of the home, we are confronted with our third point—namely, the direct effect on the children. There were 108 children in these 41 families, 75 per cent of whom were under fourteen. The children whose mothers worked at home would not feel anything direct, but rather a little less physical and mental care. There were, however, 39 children of the 14 mothers who worked outside the home.

Of the 22 children of the mothers who worked full time outside the home, 6 were under the age of six, 10 between six and fourteen years, 2 between fourteen and sixteen years, and 4 sixteen years or over. Of these children, 12 were male and 10 were female. Of the 17 children of those mothers who worked part time outside of the home, 5 were under six years, 9 between six and fourteen years, 1 between fourteen and sixteen years, and 2 sixteen years or over. Of these children 8 were males and 9 females.

Thirty of these children were under fourteen, 11 under six. Although many of them needed a mother's care, a number were left alone and some were placed out, but the burden of care in most cases was transferred to other relatives. In this group of 14 families, two children worked, the "children" being a man of twenty-five and a girl of sixteen; hence there was no social difficulty. Two of the children left alone were old enough to be able to care for themselves. One child of eight was alone all day except when in school and was locked out of the tenement until her mother returned from a day's work. In a family of six who were alone while the mother worked from six to nine every evening, children of ten, nine, seven, five, and three were left in the charge of a twelve-year-old girl.

Inquiry into the question of whether the children are at work because of the illness of their father showed that there was no increase in child labor. There were no children working under fourteen years of age, 2 between the ages of fourteen and sixteen, and 6 at sixteen years or over. These 8 children were members of 5 of the 41 families.

There were in addition a few young people who before the illness merely added to the family income, but who thereafter became the sole support of the family. In one case a daughter of eighteen, in another two sons of seventeen and sixteen, carried the burden of family support.

In 3 families 11 children, or one-tenth of the total children, were placed out. Most of these placements were made by private charitable institutions. This leads to the question of financial aid, which was received by 27 families. Permanent aid was necessary in 26 families. This aid was given in 13 cases by public agencies, in 5 by private agencies, and in the remaining 8 by relatives. One additional family needed temporary aid only. These figures represent the status at the time of the investigation, when the patient had been committed some time. If we include the rather prolonged temporary aid in two additional families, we have 28, or over two-thirds, of the families who were aided at one time or another more or less permanently.

Aid was received from two sources in 8 families. In most of these the supplementary aid was given by the wife's family. In other cases in which aid was received, the mother worked full or part time in addition. The entire support of the 41 families at the time of investigation is shown in the following table:

NO OUTSIDE AID

Support	*Families*
Wife	7
Wife's family	6
Wife and wife's family	3
Children	2
Wife and daughter	2
Wife and son	2
Wife and patient	1
Unknown	1
Total	24

PUBLIC AID

Support	*Families*
Public aid	2
Public aid and wife's family	5
Public aid and wife	4
Public aid and children	2
Total	13

PRIVATE AID

Support	*Families*
Private aid	1
Private aid and wife's family	2
Private aid and children	1
Total	4

The following summary shows a comparison between the family income at the time of the investigation and at the time the patient left work:

	Number
Income when patient left work—smaller	9
Income when patient left work—larger	23
No present income—supported by wife's family	7
Unascertained	2
Total	41

In 30 of the 41 families, the family income at the time of the investigation was less than when the patient left work. This indicates a general decline in the standard of living.

To summarize, then, in a normally self-supporting group of families, the entrance of paresis had the following effects:

1. Over one-half of the patients were receiving normal salaries at the time of admission to a state hospital.
2. Between one-half and three-fourths, however, showed a decline in working capacity.
3. This decline varied from one month to two years.
4. In spite of this decline, most of the patients were not discharged, especially by firms with whom they had worked for years.
5. Almost one-half were irregular at work or changed jobs frequently, but only a few changed to less skilled labor.
6. Over one-half gave a medical cause for finally leaving work, while the others gave an industrial cause.
7. Very few were out of work for a long time before admission.
8. Although the wages were not markedly decreased nor the patient out of work for a long time before admission, the eating up of savings followed by the sudden cutting off of the income shows that a little less than one-half of the wives went to work because of the patient's illness, three-fourths of them working outside the home.
9. Of 39 children whose mothers worked outside the home, 30 were under fourteen and had to be cared for by other relatives.
10. There was no increase in the number of children working, though some children already working had to assume heavier burdens than normally.

11. Only a few families were forced to place out children.

12. Two-thirds of the families received permanent aid because of the commitment of the patient. This aid was from public and private agencies and relatives.

13. At the time of the investigation, almost three-fourths of the families had less income than when the patient left work.

RECORDS AND STATISTICS IN OCCUPATIONAL THERAPY *

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OCCUPATIONAL therapy is passing through a transition stage. From an incidental, unorganized activity of our state hospitals, it is developing into an elaborate agency for the restoration or improvement of disordered minds. Our best institutions for the insane are now schools as well as hospitals, and it is believed that in the days to come the school will constitute the leading remedial factor of these institutions. Improvement of methods and broadening of scope are going hand in hand in occupational therapy. The subject matter of the new science is being tested, and experiments in various states are being keenly watched.

Much of this advance in occupational therapy is due to the careful study and painstaking thought of our honored president, Mrs. Slagle. Her great service to the Illinois hospitals is an inspiration to occupational teachers throughout the country.

The active interest and progress in this field naturally cause a demand for accurate data concerning operations and results. Unfortunately no adequate accounting of the work thus far done in occupational therapy has been made. There are some good records here and there, but very few of them are available for public use.

Now, since the state hospitals for the insane throughout the country have adopted a uniform classification of mental disorders and a uniform system of statistics relative to admissions, discharges, and deaths, the way is open for a system of uniform records and statistics in occupational therapy. Much would be gained from such a system, and as most hospitals have not yet established satisfactory records in this branch of their work, it would be easy for this association to secure the general adoption of any system of records or statistics that it deems satisfactory.

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* Address given at the annual meeting of the Society for the Promotion of Occupational Therapy in Philadelphia, September 13, 1920.

In attempting to formulate a system of records or statistics, we naturally ask the purpose to be attained. Why do we need records and statistics in occupational therapy? If there is no real need for such records, we should not advocate their use. Unused and unnecessary records already crowd our hospital files, and no one wishes to add to the number.

In this work, however, certain records are as necessary as entries in a check book. If we leave everything to memory, our working balance will soon be a very uncertain or perhaps a minus quantity. We cannot possibly remember all we need to know concerning our pupils. We need records, therefore, for our own guidance.

We must also remember that we are working for others; the relatives of our patients, the hospital physicians, the superintendent, and the people of the state itself, all have an interest in our work, and we should be prepared at all times to give an accurate account of what we are doing and what we have done during preceding years.

We must go a step further. We are not servants of the present day alone, but future days and years, if not ages, need us, and we can render valuable service to others in the future as well as the present by making definite records of our accomplishments and also of our failures. Our recorded successes will point the way for others to go, while our recorded failures will show the paths to be avoided. By carefully analyzing the results of our work year by year and by comparing them with the achievements of others, we shall make rapid progress and ultimately a firm scientific basis for our work will be established.

In attempting to formulate a system of records that will fulfill the purposes outlined, I have tried to observe the principle that records should be simple, easily kept, give desired information, and constitute a harmonious system. All of the entries made must serve a purpose and be used; otherwise much waste effort will result, and the records will be poorly made.

I would recommend that four forms be used in making records in occupational therapy—namely, a prescription card, an administrative card, a class-attendance register, and a yearly statistical card. A draft of each of these forms is submitted as an appendix to this paper.

The prescription card is to be made out by the physician in charge of the patient before the patient enters a class. This presupposes a thorough knowledge of occupational therapy on the part of the physician. While the physician, as the superior officer, must direct the work, the best results will often be obtained when the prescriptions are made out after consultation with the head teacher of occupational therapy. The progress of the patient must be carefully watched, and the prescription changed as often as necessary.

The prescription card would give the name of the patient, the sex, age, diagnosis, physical diseases or defects, physical condition, mental condition, previous vocation, special aptitudes and interests, the kind of occupation needed, the frequency of rest and exercise periods, and any special instructions the physician desires to give. These data are all necessary in order that the teacher of occupational therapy may thoroughly understand the patients who enter her class.

When the patient is turned over to the teacher of occupational therapy, an individual administrative card would be made out. This would contain important reference data taken from the prescription card and would provide for a monthly record of the attendance and progress of the patient for a period of two years. Special notes concerning the patient could be entered on the back of this card. The card would be kept for ready reference in an alphabetical index file in the office of the head teacher.

The register of attendance would be kept by the classroom teacher. It would provide for a complete record of the attendance, kind of work, and progress of each member of the class for a period of one month. At the end of the month the record would be handed to the head teacher and entries therefrom would be made by a clerk on the administrative cards.

The statistical card would be made out for each patient taught in the occupational-therapy classes during the year. The data for the preparation of this card would be obtained from the administrative card and from the examination of the patient at the end of the year. The card would show the mental and physical condition of the patient at the beginning of the instruction, the kinds of instruction given, the length of time of each, and the results obtained. These cards would be used for the purpose of analyzing the results of the year, and statistical tables would be prepared therefrom. Such tables could be few or many, as desired. Those recommended for general use in state hospitals for mental diseases are:

1. Class attendance and disposal of patients classified by sex and psychosis.
2. Progress in graded work of patients classified by sex and psychosis.
3. Change in mental condition of patients classified by sex and psychosis.
4. Kinds of work and results obtained in principal groups of psychoses.

The statistics thus prepared would give definite answers to many questions concerning which no data at present are available.

The system herein outlined is submitted as a basis for the discussion of this important matter; when perfected, its general use would throw light on many obscure problems and would add greatly to the dignity and efficiency of the work in which we are engaged.

PRESCRIPTION FOR OCCUPATIONAL THERAPY

Ward Date
Name of patient Iden. no. Sex Age
Diagnosis Race
Physical diseases or defects
Physical condition
Mental condition
Previous vocation
Special aptitudes or interests
Type of occupation prescribed
Duration
Rest periods
Exercises, games, folk dancing
Special instructions

Signature of Physician

(Form 5" x 8", to be printed on heavy book paper and padded)

ADMINISTRATIVE CARD—OCCUPATIONAL THERAPY

NAME IDEN. NO. SEX WARD
DIAGNOSIS RACE
DATE OF ADMISSION 19 PREVIOUS VOCATION

At commencement of instruction:
DATE 19 AGE years
PHYSICAL DISEASES OR DEFECTS
PHYSICAL CONDITION HEIGHT ft. in. WEIGHT lbs.
MENTAL CONDITION

RECORD OF INSTRUCTION

Mo.	Work		Attendance	Progress	Mo.	Work		Attendance	Progress
	Grade	Kind				Grade	Kind		

(Notes on back of card) (Card 5″x 8″)

OCCUPATIONAL THERAPY REGISTER

Class No. Classroom Teacher

Grade Kind of work

Record of attendance for month ending 19

Name of Patient	Iden. No.	Work		Attendance																																Progress
		Grade	Kind	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	

(Form 11" x 14", to be ruled)

MALE OR
FEMALE

OCCUPATIONAL THERAPY

————————————HOSPITAL

NAME IDEN. NO.

PSYCHOSIS NO. Group Type

DATE OF ADMISSION OCCUPATION PREVIOUS TO ADMISSION

AT COMMENCEMENT OF INSTRUCTION

DATE 19 AGE OF PATIENT years

MENTAL CONDITION OF PATIENT: Negativistic apathetic depressed demented flighty over-active paranoic irritable tractable other conditions (specify)

PHYSICAL CONDITION: Weight lbs. (Normal weight lbs.) DISEASES OR DEFECTS (specify)

INSTRUCTION

(Kinds and time each kind was given during year)

RESULT AT END OF YEAR OR AT TIME OF PAROLE OR DISCHARGE OF PATIENT

MENTAL CONDITION COMPARED WITH THAT AT COMMENCEMENT OF INSTRUCTION:

[Show how each abnormal mental condition present at beginning of year has changed by writing after terms denoting condition the letters R (recovered) I (improved) UN (unimproved) or W (worse) as they may apply.]

PHYSICAL CONDITION: Weight lbs. DISEASES OR DEFECTS:

DATE OF BECOMING AN INDUSTRIAL WORKER 19

DATE OF PAROLE 19

DATE OF DISCHARGE 19

DATE OF DISCONTINUANCE OF CLASS WORK AND CAUSE 19 (Form 5″ x 8″)

OUTLINE FOR A STATE SOCIETY OF MENTAL HYGIENE

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WHEN an otherwise intelligent lady can remark that she doesn't "believe in mental hygiene; it is better to let the insane and feebleminded die out and not be kept alive by mental hygiene to propagate their kind," one can at least infer what some of the activities of the mental-hygiene society in her state have been. Such a remark shows also the need for a fuller and more widespread knowledge of what mental hygiene means and is.

Hygiene in general is concerned, through sanitation, with environments that make for health and, through personal hygiene, with the body, that it may have healthy growth and development.

Similarly, mental hygiene must be concerned with what we may call mental sanitation, both of the environment and of the person. It embraces, therefore, the mental and moral atmosphere into which the young are born, in which they grow up, and in which the adult has to live, and it seeks to keep this atmosphere clean and wholesome. As a matter of personal mental hygiene, it seeks the development of wholesome mental states, reaction types, and adjustment habits of the human being, whether infant, child, or grown-up.

Hence, even before the birth of the child, mental hygiene has its place in the prenatal clinic, to insure that the expectant mother—and the father, too—knows how to create and preserve the best atmosphere for the baby to be born into. This is especially important in the case of the unwilling or the unmarried mother and the unwelcome child.

Health centers and health councils need to be able to teach those—whether parents, other relatives, foster parents, nursemaids, nurses, governesses, or the officials and employees of child-caring agencies—who care for infants, toddlers, and those of pre-school age how to keep this atmosphere clean and wholesome, free from harmful mental contagions, in order that the right attitudes and habits may be developed during these most formative and impressionable years.

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* Read before the Mental Hygiene Division of the National Conference of Social Work, New Orleans, April 21, 1920.

It need hardly be mentioned, of course, that the public schools, with their opportunities, not only in the school itself, but often in the home, for applying the principles of mental health to all the childhood and adolescence of the land, constitute a wonderfully rich field for mental-hygiene effort. For there lies the opportunity, not only for fostering normal psychic health—what we may term ortho-psychics—but for the discovery, prevention, and correction of much undesirable mental development.

All the child-caring agencies have their mental-health problems, based on their obligation to secure for their charges such *mental,* as well as physical, surroundings as will best promote a normal, healthy development. Thus mental-hygiene interest invades this field of work.

Neither the external conditions that foster mental health nor the individual's habits of reacting can be so completely guided and controlled after school years as they can be before and during them. Nevertheless, mental hygiene is finding a field in industry, where not only can it help in vocational guidance and occupational placement, in detecting the trouble maker before he makes trouble—perhaps so guiding him that he ceases to be even a potential trouble maker—and in research as to conditions that may prevent or cause fatigue and other states that affect the psychic factors of the worker, but it may also deal with the relations between the foreman or boss on the one hand and the workman under him on the other, between employer and employed, and with other industrial relations. It may thus become one of the agencies that help to remove causes of ill-feeling, resentment, and discontent, and hence of industrial unrest.

In the field of *prevention* of *morbid* or *ineffective mental reactions,* the public schools again offer a most far-reaching and important opportunity through the introduction of special classes—the adjustment or fitting or opportunity classes, as they are sometimes called. In these some of the backward can be brought up to normal level, the dullards kept from discouragement by being set tasks within their capacities, the precocious advanced as fast as is compatible with their abilities and strength, and the nervous, peculiar, or difficult child receive special attention, guidance, and direction.

In order that the teachers in public schools may have the requisite knowledge to create the right atmosphere and to teach and train the pupils in wholesome mental habits and reactions, it is necessary that mental hygiene should be taught in the schools for prospective teachers—i. e., in normal schools and colleges. Hence the mental-hygiene movement is concerned to that extent with the curriculum of these institutions.

In order that the children in the schools may be carefully examined, that their education may be fitted to their individual capacities and needs, psychologists are needed to make and interpret the necessary tests or examinations. They are needed to make researches into the mental-health needs of children at different age levels, from infancy onward. In the late school years and in industrial life, vocational guidance and occupational placement and adjustment call for the psychologist's help. Hence a mental-hygiene program may well include an interest in the adequate training and supply of psychologists and the application of their services in these fields of applied psychology.

The *discovery* and *recognition* of *morbid* mental tendencies, reactions, and conditions of persons in home, school, shop, or factory, in penal, correctional, and charitable institutions and other places of relief or detention, and in the community at large are problems of mental medicine, solvable largely by means of mental clinics and by surveys of institutions and communities. Hence the establishment of such clinics in sufficient numbers and accessibility, the conducting of surveys, and the finding of physicians and others capable of conducting them become mental-hygiene interests.

The number of physicians with a requisite knowledge of the mental factors in disease and social maladjustments, who can conduct such clinics, make such surveys, give sound advice, and conduct or guide the various types of institutions, is very limited. To increase their number, to stimulate the study of mental hygiene and mental diseases, and to increase the facilities in the medical schools and hospitals for research and teaching in these fields are very important from the standpoint of mental hygiene.

The *care* accorded to the persons found by these investigations to have mental disease or defect or other mental handicap has been from the beginning of the movement a chief concern of those interested in mental hygiene. In this connection one thinks first of hospitals for the insane and the feebleminded, for the epileptic, inebriate, and drug addict. But all types of penal and reformatory institutions, almshouses, and other places of detention should equally be thought of.

One should also think of the large group—many of its members not in hospitals—of discharged soldiers, sailors, and marines who have nervous or mental disease or defect, for whom the government holds itself responsible.

This care involves (1) the mental atmosphere—i. e., the external conditions as they affect the patient mentally—in which the patient is to be, and (2) the medical treatment and guidance of the patient.

1. The mental atmosphere is affected by (a) the laws concerning the general organization of care; concerning the supervision, control, and care of dependents; concerning commitment and admission to, detention in, and release from institutions; concerning the length and character of sentences and commitments; concerning conditions of confinement and opportunity for instruction, labor, and other occupations in prisons and other institutions; concerning appropriations for maintenance and for increased accommodations in all types of institutions.

(b) The structure of the institution, its location and general adaptability to the purposes it is called upon to serve—especially in relation to the proper classification of inmates, that their associates may not be harmful to them—affect the atmosphere in which the inmates live.

(c) The spirit and attitude of the individuals in charge of the prisoners or patients—from the board of managers, the superintendent or warden down to the ward attendant or "keeper"—are of grave importance. These may be such as to elicit in the inmate reactions that are socially or medically harmful or they may elicit the best.

(d) The whole atmosphere of the institution will be better if it is a place for research and teaching in the field of the disabilities for the care of which the institution was established. For this reason, as well as for the advancement of knowledge of the mental factors in all forms of social maladjustment and of the conditions and causes that determine them, mental hygienists are interested in this educational function of institutions.

2. With regard to medical treatment and guidance, good care requires (a) that there shall be a sufficient number of physicians, nurses, and attendants and that they shall have the requisite degree of knowledge for taking proper care of the patients; and that the institution shall have adequate equipment for administering whatever kinds of treatment, including occupations, are best suited to the needs of the patient. These are naturally items with which mental hygienists are concerned.

(b) Enough hospitals and institutions of all types to meet the mental-hygiene needs of the community are a great consideration. Psychopathic hospitals, psychopathic wards in general hospitals, out-patient mental clinics in general hospitals, special hospitals, schools, and other places, and traveling mental clinics are some of the agencies that it is part of the effort of the mental-hygiene movement to advocate.

(c) The establishment of facilities for after-care, help in resumption of normal life in the community, and guidance in prevention of recurrences of disability fall within the scope of mental hygiene. Social-service workers who have had experience with mental cases and mental out-patient clinics, whether organized by the institution or by community effort quite independently of any special institution for the care of mental cases, are agents to accomplish these ends.

Since social-service workers in general, and especially those who assist in school, hospital, or community mental clinics, are constantly faced with problems into which mental factors enter largely, it is one of the interests of mental hygienists to see that they receive instruction in the nature of these factors and their influence and bearing on their problems and in the best ways of applying this knowledge in the care of the patient or case.

Thus, to sum up, mental hygiene touches or includes within its field of interest all human activities into which a mental factor enters. It is interested in *environments,* that they may be wholesome and exert a good influence upon the development of right mental attitudes and habits and upon the correction of wrong ones; in *persons,* that they may have the best surroundings and develop and preserve or regain the most healthful types and habits of mental reaction; and in *institutions* and *agencies,* that they may carry on investigations and researches, provide the best guidance and aid in improving environment, and teach, train, and help individuals.

Interest alone in these matters is not enough.

Interest cannot be made effective without an organization of effort. The organization, whether state-wide or local, must be coöperative and must include representatives of the various associations or agencies whose special interests are touched by those of mental hygiene. It must include also other persons possessed of public spirit, social insight, influence in the community, and at least some "visible means of support" for the society.

In Pennsylvania this organization takes the form of one committee in an association whose object is to help advance and improve all public-welfare agencies in the state. It is planned that each of the main groups of public charges—such as dependent children, prisoners, the aged and infirm, etc.—shall have its special committee of the association.

Thus far the Mental Hygiene Committee is the only one that is fully organized, with a paid director, etc.

The Mental Hygiene Committee consists of a large body of citizens resident in various parts of the state. A small executive committee, composed of persons representing the main fields that it is desired to reach, has been formed. Psychiatry, neurology, general medicine, the feebleminded in institutions, the children needing special-class instruction, the delinquents, the social worker, the Red Cross, and the general public are represented on our executive committee of nine.

Owing to special opportunities within the state, the establishment of special classes in the public schools has been for a year or more an especially desirable object for which to work, and a subcommittee is authorized, with one assistant director in charge of its work.

The state is large and has many separate communities of considerable size, rather widely separated. It is planned to form local committees in these communities, in order that there may be a more widespread and better informed public opinion in matters of mental-hygiene interest throughout the state.

In order to arouse the interest and secure the coöperation of the persons who should be drawn into such a movement in a given community, some few—not too many, two or three—projects of local interest should be selected, for most public-spirited persons active in good works like a definite, concrete object upon which to work or to which to contribute. Such objects will differ in the different communities, varying with local conditions, needs, and opportunities.

Any local problem can be shown to have its state-wide bearings, and any general object can be shown to have its local application.

In order to keep the larger aims and objects of the society or committee before the eyes of present and prospective members, to indicate the general modes of action, and to define certain general principles or policies that should actuate or guide the society, a scheme or outline of these subjects will be of help.

Such an outline should include, not only the general scope of mental hygiene itself, but the needs and opportunities local to the state or the smaller community as well.

Several outlines have been prepared by the various state societies since the mental-hygiene movement started, some very brief, not pretending to cover the whole field, others more fully elaborated. Besides these schematic outlines, there have been some excellent addresses and papers, notably those by Dr. Lewellys F. Barker of Johns Hopkins University, Dr. William A. White of Washington, Professor William H. Burnham of Clark University, and Mr. Clifford W. Beers, founder of the movement.

The outline that we have drawn up in Pennsylvania is the result of composite effort. It was begun two or three years ago by Mr. Kenneth Pray, Secretary of the Public Charities Association of Pennsylvania, and has undergone several revisions since. This latest revision, presented herewith, is not regarded as final. As new insight and experience are gained, it will continue to be modified. It is offered to you now in the hope that it may be helpful to any of you who are contemplating the organization of a mental-hygiene society or committee.

MENTAL HYGIENE COMMITTEE OF THE PUBLIC CHARITIES ASSOCIATION OF PENNSYLVANIA: ITS OBJECTS, SCOPE, FUNCTIONS, AND METHODS

I. GENERAL OBJECT

To work for the promotion, conservation, and restoration of mental health. The *promotion* of mental health involves securing a wholesome mental atmosphere in which to live, and training in wholesome ways of thinking and feeling as guides to action; the *conservation* of mental health involves the detection and prevention, and the *restoration* of mental health the relief and cure, of mental diseases, mental defects, and other mental handicaps.

II. SPECIFIC PURPOSES

1. *Research,* to promote the study of the conditions that contribute to wholesome mental activities and the study of mental disease and mental defect in all their forms and relations, and of mental factors in social maladjustments.

2. *Education,* to spread a knowledge of the conditions that foster normal mental development and health; to obtain and disseminate reliable information as to the nature, origin, and effects of mental diseases and defects and the mental elements in anti- and asocial behavior, the prevalence of these diseases and defects in the community, their relations to other social problems, effective methods of combating them, and the work now being done in Pennsylvania in these directions.

3. *Constructive service,* to coöperate with all agencies—such as schools, health councils, etc—that work for normal mental health; to coöperate with, and bring into effective coöperation with one another, all existing agencies in Pennsylvania that deal, directly or indirectly, with mental disease or mental defect or with mental factors of social maladjustments.

4. *Application of these activities to prevention,* to promote the introduction of normal mental-hygiene teaching, training, and practice into the schools and health centers and councils; to disseminate a knowledge of mental-hygiene principles among parents, teachers, and others, in order to avoid the incidence of harmful experiences and complexes in the life of the normal child, and thus to prevent the later possible development of psychoneuroses, etc.; to foster reasonable and unprejudiced attitudes toward government, work, capital, industrial unrest, race riots, and other mass antisocial activities; so to take care of de-

fectives in their earlier years that they will not develop vagrancy, prostitution, criminality, and other forms of dependency; and to stimulate communities to eradicate the venereal, alcohol, and other drug perils and other known causes and conditions that engender mental disease or defect.

III. ORGANIZATION

1. *A central, state-wide committee,* with a paid director, the committee to be composed of representative citizens in different parts of the state and those who, because of special training, experience, or professional position have special knowledge of, or interest in, mental-hygiene problems.

2. *Local branch committees,* in every important community, each to consist of the members of the state committee who reside in that community, together with other public-spirited citizens who appreciate the importance of the problems and who desire to coöperate in solving them.

IV. METHODS

1. *Research.* As occasion warrants and the finances of the committee permit, surveys and investigations will be encouraged or undertaken, as to

    a. The main facts underlying the problem in Pennsylvania;

    b. Conditions peculiar to Pennsylvania;

    c. The work now being done along mental-hygiene lines in this state;

    d. Methods in use elsewhere that could be profitably applied in this state

2. *Educational publicity,* through newspapers, magazines, pamphlets, reprints, reports, news bulletins, lectures, exhibits, etc., with the object of

    a. Defining and describing the problem as it exists;

    b. Arousing public opinion as to its importance;

    c. Acquainting citizens and taxpayers with the difficulties and opportunities confronting those who are dealing officially with the problem;

    d. Disseminating information as to means within the power of the individual for combating mental weakness, as to the social evils that foster mental disorders, as to the methods that can and must be employed by the community as a whole to check and control these disorders;

    e. Organizing and vitalizing sentiment in support of a sound legislative and administrative policy with respect to mental hygiene.

3. *Constructive coöperation,* through consultations with superintendents and managers of institutions and with other public authorities, through visits to institutions, and through correspondence and conference with social agencies and individuals that are dealing with, or are directly affected by, mental-health problems, with the objects of

    a. Helping to introduce concepts and standards of normal mental health into schools and health centers and councils;

    b. Helping to raise standards of care and treatment of mental patients in institutions;

    c. Helping to obtain public support, moral and financial, for needed improvements and extensions of institutions and agencies dealing with mental patients;

    d. Encouraging the full and effective coöperation of institutions caring for mental patients with other social agencies, public and private, and vice versa;

    e. Encouraging and assisting these institutions to reach out into the community with preventive, educational, and social service.

V. Policies for Which the Committee Stands

1. *Promotion of normal mental health throughout the state by*

a. Creating local committees on mental hygiene throughout the state, especially in connection with health centers and health councils;

b. Promoting instruction in mental hygiene to prospective teachers;

c. Promoting training and practice in mental-hygiene principles by teachers and pupils in the public schools.

2. *Systematic efforts by the state to prevent an increase of mental disease and mental defect and other mental handicaps, through the*

a. Extension of facilities for early and authoritative diagnosis and treatment of those liable to mental disorders and of mental defectives in childhood;

b. Rapid increase of provision for the discovery, observation, treatment, training, and segregation of all who are now a menace to themselves or to the community because of their mental condition;

c. Stimulation of medical research and scientific social investigations in connection with state institutions;

d. Extension of after-care through state supervision over those who have been discharged from institutions, or whose mental disorder is not so grave as to require permanent custodial care.

3. *The highest possible standards of care and treatment* of all those in Pennsylvania who are suffering from mental handicaps, in order that as many as possible of these unfortunates may be relieved or cured, that all may have an equal chance to profit by the most humane and most enlightened treatment, and that all may be made as comfortable and happy as possible.

VI. Points of View

1. *The Insane or Mentally Diseased*

a. So-called insanity is a disease, requiring for its proper treatment the facilities of a well-equipped hospital and in addition many special appliances.

b. This being a medical problem, the mentally ill should be under the direction of a physician of the highest type, trained in the diagnosis and treatment of mental diseases, familiar with the results of modern research and practice in that specialty. He should be surrounded by an adequate staff of physicians, nurses, and attendants, carefully selected and trained for their special tasks.

c. Every hospital for mental illness should be so constructed and managed as to permit of extended classification and reclassification of the patients, diversified instruction, recreation, and employment, for both therapeutic and humanitarian reasons, and constant individual treatment of all who can respond in any measure to such personal attentions.

d. Every hospital for mental diseases should be a center of research and of teaching. For it is in the hospital that the material for both study and instruction is gathered. Laboratories, equipment, and personnel should be adequate for these purposes. The subjects of research should be, not only physical conditions, but also clinical manifestations in the mental fields, the nature, causes, developments, and consequences of abnormal or inadequate mental processes. Instructions should be given not only to members of its own staff, but to the physicians and others in the community from which the hospital draws its patients.

e. Many forms of mental disease—including fully a third, perhaps half, of all cases admitted to institutions—are due to preventable causes, some of which are within the control of the individual and others within the control of the community. Removal of such causes, prompt identification of early symptoms, and the earliest possible advice and treatment, will be effective measures of prevention.

f. While mental disease, as such, is probably not transmissible from parent to child, the constitutional weaknesses out of which insanity arises may be transmitted. It is the duty of the present generation, therefore, to combat directly, energetically, and systematically those sources of mental disorder that are controllable, in whole or in part, by the individual or the community.

2. *The Feebleminded or Mentally Defective*

a. Feeblemindedness, being due to a defect or lack in the brain as distinguished from a disease, is in most cases permanent and incurable. Those suffering from mental defect in this sense do not "grow up" mentally; they remain as little children. They require, therefore, for proper treatment, long and patient training, careful, constant guidance, and permanent supervision.

b. Since, however, mental defect is fundamentally due to physical defects of the brain structure, and since some forms of mental backwardness are closely related to physical conditions, the feebleminded, like the insane, should be under the direction of a specially qualified physician, who will aim to remove every physical obstacle to mental progress.

c. In institutions for the feebleminded, as in hospitals for the insane, the directing physician should have an adequate staff of carefully selected and thoroughly trained physicians, nurses, and attendants, together with a corps of specially qualified teachers and vocational directors. Research and teaching, as in hospitals for mental diseases, should be acknowledged functions of these institutions. In addition to the best of bodily care and comfort, every child in such an institution should have opportunities for mental training up to the limit of his capacity, supervised recreation, vocational instruction, and productive occupation, so diversified in character as to be adapted to the individual needs and capacities of each child in the institution.

d. Every such institution should be so planned and constructed as to permit of extended classification and reclassification of the dependents, with the object of giving to each the largest possible chance to develop to the greatest degree his potential capacities.

e. Despite this most thorough and enlightened treatment, a large number of the feebleminded will always lack the capacity to manage their own affairs with prudence and to perform their duties to society, and must, therefore, remain permanently under the care of the state, in suitable institutions.

f. A smaller number, having profited by the training given them by the state, either in institutions or in special classes in the public schools, may safely be permitted to live in the community. For these, too, the state must accept permanent responsibility. Through special departments of the state institutions, or through the board of public charities, or otherwise, the state must reach out a guiding, restraining, and protecting hand to help these weaklings meet the temptations and competition of the great world, and must effectually prevent the propagation of defectives.

3. *Other Mental Deviates*

a. Finally, recognizing the close relationship between mentally abnormal and antisocial conduct—as in the problems of pauperism, vice, crime, illegitimacy, neglected childhood, alcoholism, etc.—the state must provide simple, but complete machinery by which the mental factor may be promptly identified in any case and scientifically and effectively dealt with. The whole health, educational, charitable, and reformatory systems of the state must be so organized as to leave no gap where the mentally abnormal or subnormal citizen is left without the oversight, guidance, and treatment adapted to his peculiar needs.

VII. Special Recommendations

1. Introduction of a program of mental hygiene in the public-school system and coöperation with state and other health authorities in making mental hygiene a part of general health work.

2. State care of all the dependent insane, drug addicts, inebriates, epileptics, and feebleminded in institutions owned and controlled by the state should be established as the definite goal of the state's policy, to be arrived at by progressive stages, in perhaps the following manner:

a. Complete the two new state hospitals for the insane at once;

b. Authorize one additional state hospital at the next session;

c. Increase the capacity of existing state institutions to the limit of efficiency, by adding such special wards and buildings as they may lack, respectively, and by founding farm colonies in connection with them;

d. Raise and enforce standards of care in county and local institutions, as a prerequisite of state aid, so that within a reasonable time only the best could survive;

e. Convert these, as occasion offers, into annexes, branches, or colonies of state hospitals.

3. Convert the Committee on Lunacy, of the Board of Public Charities, into a Board or Bureau for Mental Hygiene, and give to this board full power over all institutions and agencies dealing with the feebleminded, inebriate, epileptic, and drug addicts, as it now has power over the insane.

4. Authorize, by legislation and adequate appropriations, the organization of well-equipped *out-patient, social-service, and after-care departments* in existing institutions for mental patients, and establish a state-wide system of free *mental clinics* or dispensaries.

5. Organize psychopathic wards in general hospitals, and establish psychopathic hospitals in a few large centers, to which persons suffering from mental disease or defect, or threatened with mental or nervous breakdown, can be referred for observation and treatment, and in which research and teaching shall be integral parts of the administration.

6. Enact a law, uniform for all institutions of the same class, permitting, under proper safeguards, as in the case of the insane, the commitment of mentally defective persons to institutions, for observation and treatment, and authorizing the detention of such persons, with similar safeguards, so long as is necessary for their own protection or that of the community.

7. Increase very largely the provision now made by the state for the care of mental defectives in institutions, by enlarging the Village for Feebleminded

Women at Laurelton and the Eastern State Institution at Spring City, and by creating a new institution or separate department for defective delinquents.

8. Encourage, with state aid, the establishment of special schools and classes in the public schools for backward and defective children.

9. Provide for the mental examination of persons brought before juvenile and criminal courts, and authorize the court, under proper conditions, to commit such persons, when their mental condition warrants, to suitable institutions, for observation, treatment, and training.

10. Authorize and require a systematic examination of the inmates of penal and reformatory institutions, to determine their mental condition, and provide for the transfer to institutions for defective delinquents, as soon as created, or other appropriate institutions, of those whose mental conditions warrant such action.

SOCIAL FACTS RELATIVE TO PATIENTS WITH MENTAL DISEASES

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THE purpose of this study is to show the social significance of certain facts relative to patients admitted to state hospitals for mental diseases. It is based upon statistics compiled in accordance with the uniform system adopted by the American Medico-Psychological Association and promulgated by the National Committee for Mental Hygiene. It presents data concerning nativity, citizenship, marital condition, environment, economic condition, age distribution, and alcoholic habits of patients who entered hospitals for mental diseases for the first time during the fiscal year 1919. In the April number of MENTAL HYGIENE[1] these same admissions are studied from the point of view of their types of mental disease.

The 46 state hospitals represented in this study are located as follows: Arizona 1, Colorado 1, Iowa 4, Maine 2, Massachusetts 12, Nebraska 3, New Hampshire 1, New York 15, Rhode Island 1, South Carolina 1, South Dakota 1, and Virginia 4. On account of the wide geographical distribution and the large number of patients included, the data here presented may be considered as typical for the country as a whole, though they represent only about one third of the new admissions to all our hospitals.

The logical approach to the study of patients in institutions for mental disease is through the first admissions. It is highly important to distinguish them from readmissions. Under the heading "first admissions" are included patients admitted for the first time to any hospital for the treatment of mental diseases, except institutions for temporary care only. This study, as indicated above, is concerned primarily with first admissions.

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[1] *Mental Diseases in Twelve States,* 1919. By Horatio M. Pollock and Edith M. Furbush. MENTAL HYGIENE, Vol. V, pp. 353-389, April, 1921.

Extent of Problem in the United States

(See tables 1 and 2, pages 600 and 601.)

The operations of the hospitals included in this review are shown in the following outline:

On books at beginning of the year		79,039
First admissions	16,176	
Readmissions	4,476	
Transfers	1,660	
Total received during the year		22,312
Discharged as recovered	3,325	
As improved	4,025	
As unimproved	2,041	
As without psychosis	886	
Transferred to other institutions for mental diseases	1,745	
Otherwise discharged	60	
Died	9,309	
Total discharged, transferred, and died during the year		21,391
On books at end of the year		79,960

At the end of the year 1919, there were approximately 250,000 patients with mental diseases on the books of hospitals for their treatment in this country. Assuming that the group included in this study is representative, it may be concluded that during the year 1919 there were approximately 50,000 new admissions with mental disease to the hospitals in this country and 14,000 readmissions. On the same basis there were over 32,000 discharged (not including transfers and deaths), of whom 10,400 had recovered at the time of their discharge, 12,600 were improved, 6,400 were unimproved, 2,800 were found not to have been insane, and approximately 30,000 died during the year in all the hospitals for mental diseases in this country. On account of the influenza epidemic during that year, the death rate was undoubtedly higher, and the recovery and improvement rates correspondingly lower, than under normal conditions.

Table 2 gives the sex distribution of the new admissions, and the rates per 100,000 of general population. Of the 16,176 first admissions, 8,702, or 53.8 per cent, were males, and 7,474, or 46.2 per cent, were females. In all states except New Hampshire the number of males exceeded the females. In the group studied, there were 116 males to each 100 females. The number of males to each 100 females among the first admissions and in the general population for each state is shown in the following table:

State	Among first admissions	In general population
Arizona	342	122
Colorado	151	110
Iowa	132	105
Maine	125	103
Massachusetts	113	96
Nebraska	129	108
New Hampshire	97	101
New York	111	100
Rhode Island	113	97
South Carolina	105	99
South Dakota	148	113
Virginia	117	102

The greatest disparity in sexes is found in Arizona, with over three times as many male first admissions as female. Colorado and South Dakota come next, with three males for every two females among their first admissions.

In the various states, marked differences are found in the rates of the first admissions per 100,000 of general population. Massachusetts is found to have the highest rate of first admissions per 100,000 of general population. This is due largely to the free access to the hospitals in this state on account of its laws for voluntary admission, temporary care, and observation. Wide variations are also found in the rates for the two sexes in the several states.

NATIVE AND FOREIGN BORN

(See table 3, page 602.)

Table 3 shows the nativity of the 15,384 first admissions to the state hospitals of eleven states. The native born numbered 9,410, or 61.2 per cent, of the total, the foreign born 5,833, or 37.9 per cent, while the nativity of 139 was unascertained, and 2 were born at sea.

State	Native born		Foreign born	
	Number	Per cent	Number	Per cent
Arizona	112	50.7	103	46.6
Colorado	317	69.4	125	27.4
Iowa	705	79.6	152	17.2
Maine	344	73.8	118	25.3
Massachusetts	2,093	55.9	1,635	43.6
Nebraska	344	67.3	146	28.6
New Hampshire	197	67.5	81	27.7
New York	3,667	52.9	3,246	46.8
Rhode Island	191	58.2	135	41.2
South Dakota	170	71.4	56	23.5
Virginia	1,270	96.9	36	2.7
Total	9,410	61.2	5,833	37.9

The large number of foreign-born patients emphasizes the need of more careful examination of immigrants at the ports of entry. New York and Massachusetts together received 4,881, or 83.7 per cent, of the foreign born in these twelve states. The high percentage of foreign born among the first admissions in Arizona is due to the large number born in Mexico, which constitute 29.4 per cent of the total first admissions for that state. Ireland contributed the greatest number to the foreign born in Massachusetts, closely followed by Canada. Germany furnished the largest number of foreign born in Nebraska. Canada was the birthplace of the largest number of foreign-born first admissions in Maine and New Hampshire. Italy furnished 511 of the foreign born for New York State, followed by Russia with 505, Ireland with 494, Germany with 400, and Austria with 306. Ireland, Italy, and Canada contributed practically all of the foreign born for Rhode Island. Of South Dakota's 56 foreign born, 13 were from Germany, 11 from Norway, and 9 from Sweden. There were the smallest number of foreign born in Virginia—a total of only 36, of whom 8 were born in England.

The following summary shows the number and percentage of first admissions for those countries in which more than 100 of the foreign-born first admissions were born.

Country	Number of first admissions	Per cent of total first admissions
Ireland	953	6.2
Russia	753	4.9
Italy	733	4.8
Canada	608	4.0
Germany	539	3.5
Austria	402	2.6
England	332	2.2
Poland	195	1.3
Sweden	193	1.3
Hungary	132	0.9
Greece	110	0.7

The following table shows the rates per 100,000 of the native-born and foreign-born population of the first admissions in eleven states:

State	RATE PER 100,000 OF GENERAL POPULATION OF SAME NATIVITY Native-born first admissions	 Foreign-born first admissions
Arizona	45.5	137.4
Colorado	39.3	106.0
Iowa	32.7	66.0
Maine	52.3	109.7
Massachusetts	76.7	152.2
Nebraska	30.3	95.9
New Hampshire	56.3	88.3
New York	49.0	116.8
Rhode Island	45.0	77.7
South Dakota	31.1	66.5
Virginia	56.3	118.5
Total	50.1	118.7

CITIZENSHIP

(See table 4, page 604.)

Table 4 presents the citizenship of the new admissions to the state hospitals of ten states for the year 1919. Of the 15,163 patients included in this table, 9,278, or 61.2 per cent, were citizens by birth. The most marked feature of the table is the large number of aliens—3,135, or 20.7 per cent of the total first admissions and 21.7 per cent of those whose citizenship was ascertained. If we add to this figure the 2,007 citizens by naturalization, the total constitutes 33.9 per cent of the first admissions and 35.7 per cent of those patients whose citizenship was ascertained. Most of these aliens—92 per cent—are found to have entered New York and Massachusetts hospitals. The following summary shows the distribution of aliens:

State	Number	Per cent of total first admissions
Colorado	1	0.2
Iowa	52	5.9
Maine	46	9.9
Massachusetts	1,046	27.9
Nebraska	20	3.9
New Hampshire	32	11.0
New York	1,853	26.7
Rhode Island	76	23.2
South Dakota	2	0.8
Virginia	7	0.5
Total	3,135	20.7

It has long been contended by the states of New York and Massachusetts that the Federal Government should assume the care of the alien insane. These states claim that under existing conditions the burden of the care of the alien insane falls upon them in disproportionate measure. This claim is borne out by the data presented in the above summary.

It has been found in New York State that the aliens among the first admissions have the same relation numerically to the first admissions as the aliens under treatment bear to the total patient population. Assuming that this is true for the other states, there are at present at least 16,000 aliens with mental diseases under treatment in these states alone. The average cost of maintenance per patient in a state hospital is $250. On this basis, the annual cost of maintaining alien patients with mental diseases in these states alone is over $4,000,000.

The significance of the problem of the alien insane in New York State was brought out in a study prepared by Dr. Spencer L. Dawes, Special Commissioner for the Alien Insane, entitled *Report on the Alien Insane in the Civil Hospitals of New York State.* It strongly urges the exclusion, so far as possible, of both mentally diseased and mentally defective persons at the ports of entry, and the deportation of those who may have been admitted and have not become citizens. Although this report was published in 1914, it contains information that is not available elsewhere.

MARITAL CONDITION

(See table 5, page 605.)

Table 5 shows the marital condition of the first admissions to the state hospitals in twelve states. Of those patients whose marital condition was ascertained, 41.0 per cent were single, 42.6 per cent married, 13.5 per cent widowed, 2.9 per cent separated or divorced. The following table shows the corresponding percentages by sexes for the different states:

Per Cent Distribution of Marital Condition of First Admissions in Twelve States

	SINGLE		MARRIED		WIDOWED		SEPARATED OR DIVORCED	
State	Males	Females	Males	Females	Males	Females	Males	Females
Arizona	72.5	28.9	18.3	62.2	7.8	6.7	1.3	2.2
Colorado	52.2	24.8	34.0	55.9	8.7	14.3	5.1	5.0
Iowa	43.5	26.4	42.9	53.4	11.5	14.7	2.0	5.5
Maine	49.4	30.4	34.5	41.1	11.0	21.3	5.1	7.2
Massachusetts	47.9	39.9	40.0	40.9	9.7	17.7	2.3	1.5
Nebraska	44.0	32.1	38.4	53.4	12.3	11.3	5.3	3.2
New Hampshire	43.6	33.8	41.4	42.3	11.3	16.9	3.8	7.0
New York	48.0	32.0	40.2	45.1	8.6	19.6	3.2	3.3
Rhode Island	49.1	29.2	36.8	42.2	10.5	24.0	3.5	4.5
South Carolina	39.7	27.2	47.3	53.2	11.3	16.7	1.8	2.8
South Dakota	56.3	19.8	32.4	66.7	9.2	12.5	2.1	1.0
Virginia	49.1	31.3	40.8	49.6	8.6	17.8	1.4	1.3
Total	48.0	32.9	39.7	46.0	9.4	18.2	2.9	3.0

To a casual observer of the above summary, the high percentage of single men and of married women would seem to indicate that, from a mental-hygiene point of view, marriage is beneficial to men, but detrimental to women. The fact that 48 per cent of the males were single and 46 per cent of the females married is due partly to the large number of men who enter hospitals in early life with dementia praecox, and in part to the fact that women as a rule marry at an earlier age than do men.

ENVIRONMENT

(See table 6, page 606.)

The terms used in this table are the same as in the classification of the Federal Census Bureau. "Urban" applies to places having a population of 2,500 or more, and "rural" to all others.

Of the ascertained cases, 8,439, or 71.8 per cent, were from urban environment, and 3,314, or 28.2 per cent, from rural. Based upon the general population of the same environment, 69.9 per 100,000 came from urban districts and 37.9 per 100,000 from rural.

Per Cent Distribution of Environment of First Admissions in Nine States

State	URBAN		RURAL		UNASCERTAINED	
	Males	Females	Males	Females	Males	Females
Colorado	47.2	55.4	47.2	37.1	5.5	7.5
Iowa	57.1	59.9	37.3	38.5	5.6	1.6
Maine	51.4	51.2	48.6	48.8	....	....
Nebraska	42.4	48.4	44.4	45.7	13.2	5.8
New York	87.0	86.9	12.5	12.4	0.5	0.8
Rhode Island	96.6	96.1	3.4	3.9	....	....
South Carolina	25.3	24.7	72.0	72.0	2.7	3.3
South Dakota	39.4	74.0	60.6	26.0	....	....
Virginia	42.3	42.3	57.4	57.7	0.3	....
Total	69.8	71.8	28.5	26.9	1.7	1.3

The rates of first admissions per 100,000 of general population of the same environment are as follows:

	Males	Females	Total
Urban..........	74.3	65.6	69.9
Rural...........	40.2	35.5	37.9

These data would not support the theory frequently advanced that insanity is more prevalent in rural communities than in cities. Comparing the environment of the two sexes, it is seen that in rural districts the rate of first admissions among males is higher than that among females.

That there has been a decided movement of the population toward cities is shown by the result of the last two federal censuses. In 1910, 45.8 per cent of the general population of the country was urban, and 54.2 per cent rural. The corresponding percentages for 1920 were 51.4 per cent and 48.6 per cent. In other words, the urban population has increased 28.6 per cent, while the rural has increased only 3.1 per cent. The trend of the population from the country toward the city is further emphasized by the fact that the 1920 federal census showed that the portion of the population living in purely country districts decreased by 227,335, or six-tenths of one per cent. The movement toward cities tends to increase admissions to hospitals for mental diseases. Many persons who can get along without much difficulty in a rural environment break down under the stress and strain of life in a large city. Certain types of mental disease are found to be much more frequent in cities than in rural districts—for example, general paralysis and alcoholic psychoses.

Economic Condition

(See table 7, page 607.)

The headings in this table are used as in the United States census classification and are thus defined: "Dependent," lacking in the necessities of life or receiving aid from public funds or persons outside the immediate family; "marginal," living on daily earnings, but accumulating little or nothing, being on the margin between self-support and dependency; "comfortable," having accumulated resources sufficient to maintain self and family for at least four months.

Data with reference to the economic condition of first admissions for the year 1919 were received from nine states, including 13,853 patients. Of this number, 1,857, or 13.4 per cent, were dependent; 9,178, or 66.3 per cent, were marginal; and 2,358, or 17.0 per cent, were comfortable, while the economic condition of 460, or 3.3 per cent, was unascertained. The following summary presents corresponding percentages by sexes, with the unascertained cases excluded:

	Males	Females	Total
Dependent	13.2	14.6	13.9
Marginal	70.2	66.7	68.5
Comfortable	16.6	18.7	17.6
Total	100.0	100.0	100.0

The wide variations in the several states may be due to a misinterpretation of the terms employed. The fact that 1918 and 1919 were unusual years from an economic viewpoint may account in part for the relatively large number of persons classified as "comfortable." Conditions of unusual prosperity prevailed during the period included in this review, especially in rural districts.

It is regrettable that data are not available concerning the economic condition of the general population, so that comparisons might be made between these first admissions and the general population in this respect.

AGE DISTRIBUTION

(See table 8, page 608.)

In Table 8 are shown for the twelve states the age distribution of the first admissions for the year studied. The greatest numbers are admitted from twenty-five to forty years of age, with a gradual decline thereafter.

Percentage Distribution of Ages of First Admissions to State Hospitals in Twelve States, 1919

Age groups	Males	Females	Total
Under 15 years	0.8	0.8	0.8
15–19 years	6.3	5.5	6.0
20–24 years	9.4	9.9	9.6

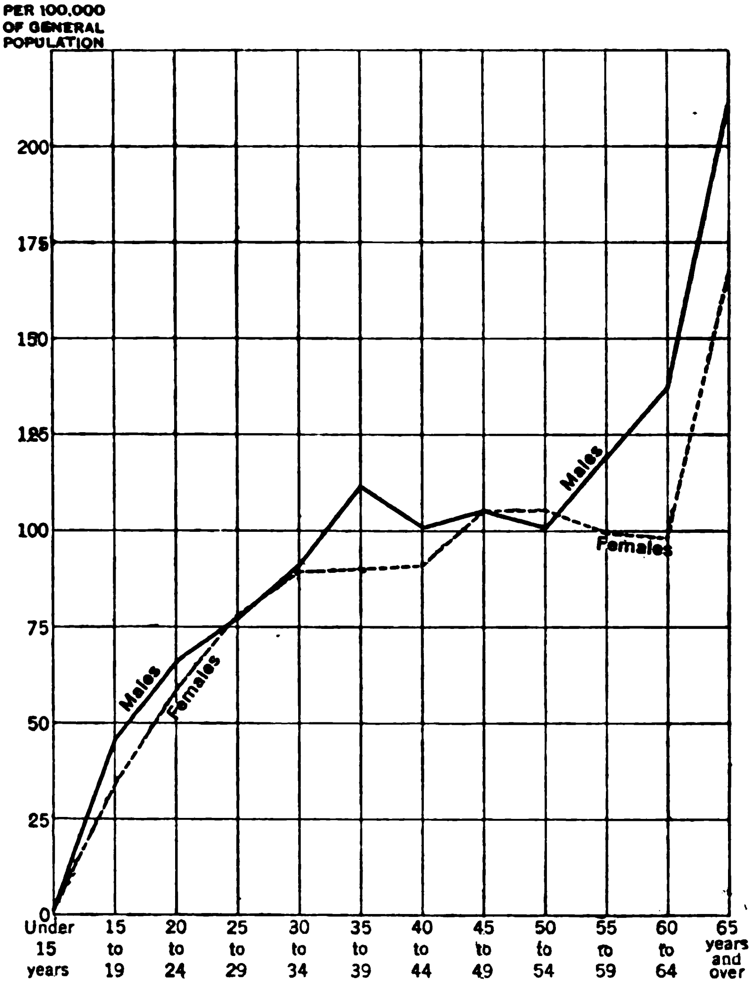
Age groups	Males	Females	Total
25–29 years	10.4	11.8	11.0
30–34 years	10.8	11.5	11.1
35–39 years	12.2	10.9	11.6
40–44 years	9.4	9.2	9.3
45–49 years	8.2	8.9	8.6
50–54 years	6.9	7.6	7.2
55–59 years	5.7	5.2	5.5
60–64 years	5.3	4.4	4.9
65 years and over	13.9	13.8	13.9
Unascertained	0.8	0.6	0.7
Total	100.0	100.0	100.0

The following summary shows the results of comparing the ages of the first admissions with the estimated number of persons in the general population by sexes and age groups:

Age groups	ADMISSIONS PER 100,000 OF GENERAL POPULATION		
	Males	Females	Total
Under 15 years	1.8	1.5	1.7
15–19 years	45.8	33.7	39.7
20–24 years	65.4	58.5	61.9
25–29 years	77.4	78.6	78.0
30–34 years	91.9	89.2	90.6
35–39 years	112.2	90.6	101.7
40–44 years	101.8	91.7	96.9
45–49 years	105.5	105.6	105.5
50–54 years	101.4	105.1	103.2
55–59 years	119.5	99.7	110.0
60–64 years	137.4	98.9	118.3
65 years and over	210.4	167.8	188.4
Total	67.8	59.8	63.8

The accompanying chart shows that the rates based upon the general population of the several age groups increase with advancing years. In the age groups under fifty years, the highest rate for males is from thirty-five to thirty-nine years, and for females from forty-five to forty-nine.

RATE OF MALE AND OF FEMALE FIRST ADMISSIONS TO STATE HOSPITALS IN TWELVE STATES PER 100,000 OF GENERAL POPULATION OF THE SAME SEX AND AGE



USE OF ALCOHOL

(See table 9, page 611.)

Table 9 presents a summary of the use of alcohol by first admissions to state hospitals in the nine states for which these data were available. Of the 14,154 patients included in the table, 6,533, or 46.2 per cent, were abstinent; 4,244, or 30.0 per cent, were temperate; 2,145, or 15.2 per cent, were intemperate; and the alcoholic habits of 1,232 were unascertained. The following summary gives the corresponding percentages by sexes, excluding the unascertained cases.

	Males	Females	Total
Abstinent........	31.5	72.3	50.6
Temperate.......	42.2	22.1	32.8
Intemperate......	26.3	5.6	16.6
Total.........	100.0	100.0	100.0

Over half of those first admissions whose habits with respect to alcohol were ascertained were found to be abstinent, and only one in six was intemperate—one in eighteen among the women and one in four among the men. These figures are in distinct contradiction to the assumption sometimes made that alcohol is the principal cause of mental disease.

Dr. H. M. Pollock, Statistician of the New York State Hospital Commission, recently made a study[1] of the use of alcohol and drugs among first admissions to the New York State hospitals from 1909 to 1920, inclusive. This study shows a decline in the incidence of mental disease, as well as in the number of new admissions with a history of intemperate use of alcohol, and strikes a very hopeful note for the future.

The reduction in the use of alcohol, the gradual elimination of venereal diseases, and the dissemination of more complete knowledge of the principles of mental hygiene tend to lower the rates of mental disease. On the other hand, the crowding of the population into cities, the increasing economic stress, and the reduction of the birth rate among the more stable elements of the population are conditions unfavorable to mental health.

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[1] *Decline of Alcohol and Drugs as Causes of Mental Disease.* By H. M. Pollock. MENTAL HYGIENE, Vol. 5, pp. 123-129, January, 1921.

Table 1—Movement of patients with mental diseases in state hospitals in twelve states, for the fiscal year ending in 1919

STATE	On books at beginning of year	ADMITTED DURING YEAR				DISCHARGED FROM BOOKS DURING YEAR								On books at end of year
		First admissions	Readmissions	Transfers	Total	Recovered	Improved	Unimproved	Without psychosis	Transferred	Otherwise discharged	Died	Total	
Arizona	542	221	17	......	238	38	97	15	1	......	......	103	254	526
Colorado	1,741	437	20	......	457	18	17	2	3	......	......	232	272	1,926
Iowa	5,425	886	189	20	1,095	252	51	29	3	119	44	502	1,000	5,520
Maine	1,918	466	131	17	614	77	81	41	45	16	......	246	506	2,026
Massachusetts	16,495	3,746	1,490	399	5,635	449	1,059	1,204	542	440	......	1,865	5,559	16,571
Nebraska	2,661	511	73	2	586	24	118	19	3	3	......	252	419	2,828
New Hampshire	1,358	292	81	......	373	29	73	29	29	......	......	199	359	1,372
New York	38,772	6,929	1,918	1,210	10,057	1,600	1,894	503	52	1,159	......	4,592	9,800	39,029
Rhode Island	1,700	328	77	......	405	81	88	48	6	......	......	194	417	1,688
South Carolina	2,188	812	207	......	1,019	215	219	63	92	......	......	278	867	2,340
South Dakota	1,077	238	9	......	247	47	23	17	4	......	16	92	199	1,125
Virginia	5,162	1,310	264	12	1,586	495	305	71	106	8	......	754	1,739	5,009
Total	79,039	16,176	4,476	1,660	22,312	3,325	4,025	2,041	886	1,745	60	9,309	21,391	79,960

Table 2—First admissions to state hospitals for mental diseases in twelve states, compared with the general population for the year 1919

State	Number			Rate per 100,000 of General Population		
	Males	Females	Total	Males	Females	Total
Arizona	171	50	221	96.6	34.7	68.8
Colorado	263	174	437	54.1	39.6	47.2
Iowa	504	382	886	41.3	32.8	37.1
Maine	259	207	466	66.8	54.8	60.9
Massachusetts	1,985	1,761	3,746	106.3	90.9	98.5
Nebraska	288	223	511	43.1	36.1	39.7
New Hampshire	144	148	292	65.0	67.2	66.1
New York	3,650	3,279	6,929	71.2	63.9	67.5
Rhode Island	174	154	328	59.0	50.8	54.8
South Carolina	415	397	812	50.0	47.4	48.7
South Dakota	142	96	238	42.4	32.4	37.7
Virginia	707	603	1,310	61.2	53.4	57.3
Total	8,702	7,474	16,176	68.1	59.3	63.8

Table 3—Nativity distribution of first admissions to state hospitals for mental diseases in eleven states, 1919

COUNTRY OF BIRTH	TOTAL		ARIZONA		COLORADO*		IOWA		MAINE		MASSACHUSETTS	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
United States	9,410	61.2	112	50.7	317	69.4	705	79.6	344	73.8	2,093	55.9
Austria	402	2.6	4	1.8	16	3.5	8	0.9			48	1.3
Belgium	13	0.1					1	0.1			3	0.1
Bohemia	58	0.4					10	1.1			2	0.1
Canada	608	4.0	2	0.9	9	2.0	9	1.0	67	14.4	336	9.0
China	11	0.1									5	0.1
Denmark	50	0.3			5	1.1	12	1.4			2	0.1
England	332	2.2	2	0.9	11	2.4	7	0.8	4	0.9	123	3.3
Finland	56	0.4	1	0.5	1	0.2			2	0.4	22	0.6
France	46	0.3					3	0.3			11	0.3
Germany	539	3.5	5	2.3	7	1.5	32	3.6	3	0.6	42	1.1
Greece	110	0.7	4	1.8			5	0.6	1	0.2	38	1.0
Holland	28	0.2					11	1.2			2	0.1
Hungary	132	0.9	1	0.5	1	0.2	1	0.1			3	0.1
Ireland	953	6.2	3	1.4	9	2.0	8	0.9	7	1.5	385	10.3
Italy	733	4.8	3	1.4	16	3.5	4	0.5	2	0.4	169	4.5
Mexico	80	0.5	65	29.4	7	1.5	2	0.2				
Norway	69	0.4			3	0.7	8	0.9	2	0.4	9	0.2
Poland	195	1.3	1	0.5			1	0.1	7	1.5	69	1.8
Portugal	52	0.3	2	0.9							39	1.0
Roumania	39	0.3							1	0.2	1	0.0
Russia	753	4.9	2	0.9	19	4.2	8	0.9	12	2.6	182	4.9
Scotland	68	0.4	1	0.5	2	0.4					21	0.6
Spain	29	0.2	1	0.5							4	0.1
Sweden	193	1.3	3	1.4	15	3.3	17	1.9	2	0.4	60	1.6
Switzerland	30	0.2			2	0.4	4	0.5			1	0.0
Turkey	74	0.5	1	0.5							26	0.7
West Indies	76	0.5									14	0.4
Other countries	†106	0.7	2	0.9	2	0.4	1	0.1	8	1.7	19	0.5
Unascertained	139	0.9	6	2.7	15	3.3	29	3.3	4	0.9	17	0.5
Total	15,384	100.0	221	100.0	457	100.0	886	100.0	466	100.0	3,746	100.0

* Includes 20 readmissions.

† Includes 2 patients born at sea.

Table 3—Nativity distribution of first admissions to state hospitals for mental diseases in eleven states, 1919—Concluded

COUNTRY OF BIRTH	NEBRASKA		NEW HAMPSHIRE		NEW YORK		RHODE ISLAND		SOUTH DAKOTA		VIRGINIA	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
United States	344	67.3	197	67.5	3,667	52.9	191	58.2	170	71.4	1,270	96.9
Austria	9	1.8	1	0.3	306	4.4	5	1.5	1	0.4	4	0.3
Belgium	2	0.4	1	0.3	6	0.1	......	......	......	......	......	......
Bohemia	17	3.3	......	......	25	0.4	......	......	3	1.3	1	0.1
Canada	2	0.4	45	15.4	113	1.6	22	6.7	3	1.3	......	......
China	......	......	1	0.3	5	0.1	......	......	......	......	......	......
Denmark	6	1.2	......	......	20	0.3	......	......	3	1.3	2	0.2
England	7	1.4	4	1.4	147	2.1	18	5.5	1	0.4	8	0.6
Finland	1	0.2	3	1.0	26	0.4	......	......	......	......	......	......
France	1	0.2	1	0.3	26	0.4	3	0.9	1	0.4	......	......
Germany	27	5.3	3	1.0	400	5.8	4	1.2	13	5.5	3	0.2
Greece	3	0.6	3	1.0	53	0.8	1	0.3	......	......	2	0.2
Holland	3	0.6	......	......	12	0.2	......	......	......	......	......	......
Hungary	1	0.2	......	......	121	1.7	......	......	1	0.4	3	0.2
Ireland	6	1.2	8	2.7	494	7.1	28	8.5	4	1.7	1	0.1
Italy	3	0.6	......	......	511	7.4	24	7.3	......	......	1	0.1
Mexico	......	......	......	......	6	0.1	......	......	......	......	......	......
Norway	6	1.2	......	......	30	0.4	......	......	11	4.6	......	......
Poland	4	0.8	2	0.7	107	1.5	1	0.3	......	......	3	0.2
Portugal	......	......	......	......	6	0.1	5	1.5	......	......	......	......
Roumania	1	0.2	......	......	34	0.5	2	0.6	......	......	......	......
Russia	7	1.4	3	1.0	505	7.3	8	2.4	4	1.7	3	0.2
Scotland	......	......	2	0.7	37	0.5	4	1.2	1	0.4	......	......
Spain	......	......	......	......	24	0.3	......	......	......	......	......	......
Sweden	16	3.1	4	1.4	64	0.9	2	0.6	9	3.8	1	0.1
Switzerland	3	0.6	......	......	20	0.3	......	......	......	......	......	......
Turkey	......	......	......	......	39	0.6	8	2.4	......	......	......	......
West Indies	......	......	......	......	60	0.9	......	......	......	......	2	0.2
Other countries	21	4.1	......	......	50	0.7	......	......	1	0.4	2	0.2
Unascertained	21	4.1	14	4.8	15	0.2	2	0.6	12	5.0	4	0.3
Total	511	100.0	292	100.0	6,929	100.0	328	100.0	238	100.0	1,310	100.0

Table 4—Citizenship of first admissions to state hospitals for mental diseases in ten states, 1919

STATE	TOTAL			CITIZENS BY BIRTH			CITIZENS BY NATURALIZATION			ALIENS			CITIZENSHIP UNASCERTAINED		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Colorado*	271	186	457	188	129	317	77	48	125	1	.....	1	5	9	14
Iowa	504	382	886	384	322	706	40	7	47	48	4	52	32	49	81
Maine	259	207	466	186	164	350	18	25	43	40	6	46	15	12	27
Massachusetts	1,985	1,761	3,746	1,105	985	2,090	225	186	411	555	491	1,046	100	99	199
Nebraska	288	223	511	194	151	345	9	8	17	12	8	20	73	56	129
New Hampshire	144	148	292	101	97	198	6	17	23	18	14	32	19	20	39
New York	3,650	3,279	6,929	1,887	1,747	3,634	618	638	1,256	1,082	771	1,853	63	123	186
Rhode Island	174	154	328	107	80	187	25	25	50	35	41	76	7	8	15
South Dakota	142	96	238	103	72	175	15	3	18	2	.....	2	22	21	43
Virginia	707	603	1,310	683	593	1,276	11	6	17	6	1	7	7	3	10
Total	8,124	7,039	15,163	4,938	4,340	9,278	1,044	963	2,007	1,799	1,336	3,135	343	400	743

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* Includes 20 readmissions.

Table 5—Marital condition of first admissions to state hospitals for mental diseases in twelve states, 1919

MARITAL CONDITION	TOTAL			ARIZONA			COLORADO*			IOWA			MAINE			MASSACHUSETTS		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Single	4,099	2,416	6,515	111	13	124	132	40	172	215	101	316	126	63	189	940	698	1,638
Married	3,389	3,378	6,767	28	28	56	86	90	176	212	204	416	88	85	173	785	715	1,500
Widowed	805	1,335	2,140	12	3	15	22	23	45	57	56	113	28	44	72	191	310	501
Separated	133	129	262	....	1	1	7	5	12	3	8	11	4	6	10	16	7	23
Divorced	111	92	203	2	....	2	6	3	9	7	13	20	9	9	18	29	19	48
Unascertained	173	136	309	18	5	23	18	25	43	10	....	10	4	....	4	24	12	36
Total	8,710	7,486	16,196	171	50	221	271	186	457	504	382	886	259	207	466	1,985	1,761	3,746

MARITAL CONDITION	NEBRASKA			NEW HAMPSHIRE			NEW YORK			RHODE ISLAND			SOUTH CAROLINA			SOUTH DAKOTA			VIRGINIA		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Single	125	71	196	58	48	106	1,726	1,025	2,751	84	45	129	159	106	265	80	19	99	343	187	530
Married	109	118	227	55	60	115	1,443	1,446	2,889	63	65	128	189	207	396	46	64	110	285	296	581
Widowed	35	25	60	15	24	39	309	630	939	18	37	55	45	65	110	13	12	25	60	106	166
Separated	3	3	6	3	5	8	86	86	172	2	....	2	7	8	15	....	....	....	2	....	2
Divorced	12	4	16	2	5	7	29	20	49	4	7	11	....	3	3	3	1	4	8	8	16
Unascertained	4	2	6	11	6	17	57	72	129	3	....	3	15	8	23	....	....	....	9	6	15
Total	288	223	511	144	148	292	3,650	3,279	6,929	174	154	328	415	397	812	142	96	238	707	603	1,310

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* Includes 20 readmissions.

Table 6—Environment of first admissions to state hospitals for mental diseases in nine states, compared with the general population for 1919*

STATE	URBAN				RURAL			
	NUMBER			Rate per 100,000	NUMBER			Rate per 100,000
	Males	Females	Total		Males	Females	Total	
Colorado	128	103	231	51.5	128	69	197	41.3
Iowa	228	229	517	60.4	188	147	335	21.9
Maine	133	106	239	80.8	126	101	227	48.3
Nebraska	122	108	230	58.1	128	102	230	25.8
New York	3,174	2,848	6,022	71.3	458	405	863	47.7
Rhode Island	168	148	316	54.2	6	6	12	77.5
South Carolina	105	98	203	70.7	299	286	585	42.4
South Dakota	56	71	127	127.8	86	25	111	20.9
Virginia	299	255	554	84.7	406	348	754	46.3
Total	4,473	3,966	8,439	69.9	1,825	1,489	3,314	37.9

* 184 patients whose environment was unascertained were excluded.

Table 7—Economic condition of first admissions to state hospitals for mental diseases in nine states, 1919

State	Total			Dependent			Marginal			Comfortable			Unascertained		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Colorado*	271	186	457	6	......	6	254	174	428	4	2	6	7	10	17
Iowa	504	382	886	95	53	148	194	170	364	152	133	285	63	26	89
Maine	259	207	466	49	36	85	19	6	25	182	165	347	9	......	9
Massachusetts	1,985	1,761	3,746	207	274	481	1,403	1,257	2,660	302	229	531	73	1	74
Nebraska	288	223	511	90	101	191	145	90	235	35	21	56	18	11	29
New Hampshire	144	148	292	62	57	119	60	52	112	20	38	58	2	1	3
New York	3,650	3,279	6,929	394	357	751	2,842	2,395	5,237	290	414	704	124	113	237
Rhode Island	174	154	328	25	27	52	63	30	93	84	97	181	2	......	2
South Dakota	142	96	238	15	9	24	9	15	24	118	72	190	......	......	......
Total	7,417	6,436	13,853	943	914	1,857	4,989	4,189	9,178	1,187	1,171	2,358	298	162	460

* Includes 20 readmissions.

Table 8—Age distribution of first admissions to state hospitals for mental diseases in twelve states, 1919

Age Group	Total				Arizona				Colorado*				Iowa			
	Number			Per cent	Number			Per cent	Number			Per cent	Number			Per cent
	M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.	
Under 15 years	68	58	126	0.8	1	2	3	1.4	3	1	4	0.9	4	1	5	0.6
15 to 19 years	550	414	964	6.0	14	7	21	9.5	17	8	25	5.5	9	8	17	1.9
20 to 24 years	817	742	1,559	9.6	14	2	16	7.2	19	10	29	6.3	41	32	73	8.2
25 to 29 years	905	884	1,789	11.0	16	3	19	8.6	22	14	36	7.9	36	43	79	8.9
30 to 34 years	937	862	1,799	11.1	17	5	22	10.0	33	19	52	11.4	57	53	110	12.4
35 to 39 years	1,065	813	1,878	11.6	26	11	37	16.7	29	22	51	11.2	63	42	105	11.9
40 to 44 years	817	685	1,502	9.3	16	1	17	7.7	23	16	39	8.5	36	38	74	8.4
45 to 49 years	718	669	1,387	8.6	12	4	16	7.2	21	17	38	8.3	42	40	82	9.3
50 to 54 years	598	567	1,165	7.2	11	2	13	5.9	16	16	32	7.0	45	35	80	9.0
55 to 59 years	499	388	887	5.5	8	1	9	4.1	8	13	21	4.6	41	26	67	7.6
60 to 64 years	459	327	786	4.9	4	.....	4	1.8	29	7	36	7.9	36	18	54	6.1
65 to 69 years	420	273	693	4.3	6	.....	6	2.7	11	10	21	4.6	25	12	37	4.2
70 years and over	791	762	1,553	9.6	12	3	15	6.8	27	24	51	11.2	60	28	88	9.9
Unascertained	66	42	108	0.7	14	9	23	10.4	13	9	22	4.8	9	6	15	1.7
Total	8,710	7,486	16,196	100.0	171	50	221	100.0	271	186	457	100.0	504	382	886	100.0

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* Includes 20 readmissions.

Table 8—Age distribution of first admissions to state hospitals for mental diseases in twelve states, 1919—Continued

AGE GROUP	MAINE				MASSACHUSETTS				NEBRASKA				NEW HAMPSHIRE			
	NUMBER			Per cent	NUMBER			Per cent	NUMBER			Per cent	NUMBER			Per cent
	M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.	
Under 15 years	1	1	2	0.4	30	15	45	1.2	1	.....	1	0.2	3	2	5	1.7
15 to 19 years	14	9	23	4.9	136	143	279	7.4	8	9	17	3.3	7	5	12	4.1
20 to 24 years	25	11	36	7.7	184	190	374	10.0	23	21	44	8.6	11	8	19	6.5
25 to 29 years	22	18	40	8.6	190	203	393	10.5	27	27	54	10.6	11	15	26	8.9
30 to 34 years	25	21	46	9.9	248	204	452	12.1	25	26	51	10.0	12	14	26	8.9
35 to 39 years	35	21	56	12.0	225	178	403	10.8	33	32	65	12.7	19	22	41	14.0
40 to 44 years	22	13	35	7.5	184	149	333	8.9	30	23	53	10.4	9	17	26	8.9
45 to 49 years	26	21	47	10.1	173	149	322	8.6	16	16	32	6.3	13	8	21	7.2
50 to 54 years	17	25	42	9.0	136	119	255	6.8	19	13	32	6.3	10	13	23	7.9
55 to 59 years	11	18	29	6.2	117	80	197	5.3	29	12	41	8.0	6	10	16	5.5
60 to 64 years	16	8	24	5.2	105	68	173	4.6	11	9	20	3.9	5	13	18	6.2
65 to 69 years	25	5	30	6.4	87	59	146	3.9	17	7	24	4.7	10	3	13	4.5
70 years and over	20	34	54	11.6	170	204	374	10.0	38	25	63	12.3	24	15	39	13.4
Unascertained	.....	2	2	0.4	.....	.....	.....	.....	11	3	14	2.7	4	3	7	2.4
Total	259	207	466	100.0	1,985	1,761	3,746	100.0	288	223	511	100.0	144	148	292	100.0

Table 8—Age distribution of first admissions to state hospitals for mental diseases in twelve states, 1919—Concluded

AGE GROUP	NEW YORK				RHODE ISLAND				SOUTH CAROLINA				SOUTH DAKOTA				VIRGINIA			
	NUMBER			Per cent	NUMBER			Per cent	NUMBER			Per cent	NUMBER			Per cent	NUMBER			Per cent
	M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.		M.	F.	T.	
Under 15 years	13	9	22	0.3	....	....	....	....	8	16	24	3.0	....	....	....	....	4	11	15	1.1
15 to 19 years	207	137	344	5.0	10	2	12	3.7	55	39	94	11.6	8	2	10	4.2	65	45	110	8.4
20 to 24 years	312	313	625	9.0	15	13	28	8.5	47	63	110	13.5	19	10	29	12.2	107	69	176	13.4
25 to 29 years	431	419	850	12.3	22	16	38	11.6	42	46	88	10.8	13	6	19	8.0	73	74	147	11.2
30 to 34 years	399	378	777	11.2	16	18	34	10.4	30	42	72	8.9	10	15	25	10.5	65	67	132	10.1
35 to 39 years	491	336	827	11.9	20	16	36	11.0	36	45	81	10.0	18	15	33	13.9	70	73	143	10.9
40 to 44 years	375	334	709	10.2	20	11	31	9.5	28	28	56	6.9	11	12	23	9.7	63	43	106	8.1
45 to 49 years	309	316	625	9.0	17	13	30	9.1	33	32	65	8.0	12	5	17	7.1	44	48	92	7.0
50 to 54 years	258	262	520	7.5	8	14	22	6.7	22	21	43	5.3	13	6	19	8.0	43	41	84	6.4
55 to 59 years	213	178	391	5.6	11	10	21	6.4	18	10	28	3.4	7	7	14	5.9	30	23	53	4.0
60 to 64 years	173	154	327	4.7	6	4	10	3.0	27	11	38	4.7	10	2	12	5.0	37	33	70	5.3
65 to 69 years	168	123	291	4.2	8	8	16	4.9	21	17	38	4.7	11	4	15	6.3	31	25	56	4.3
70 years and over	292	314	606	8.7	21	29	50	15.2	46	23	69	8.5	9	12	21	8.8	72	51	123	9.4
Unascertained	9	6	15	0.2	....	....	....	....	2	4	6	0.7	1	....	1	0.4	3	....	3	0.2
Total	3,650	3,279	6,929	100.0	174	154	328	100.0	415	397	812	100.0	142	96	238	100.0	707	603	1,310	100.0

Table 9—Use of alcohol by first admissions to state hospitals for mental diseases in nine states, 1919

STATE	Total	Abstinent	Temperate	Intemperate	Unascertained
Colorado*	457	6	359	44	48
Iowa	886	505	132	108	141
Maine	466	169	174	93	30
Massachusetts	3,746	2,003	847	687	209
New Hampshire	292	157	45	38	52
New York	6,929	2,891	2,364	1,034	640
Rhode Island	328	138	115	51	24
South Carolina	812	464	199	63	86
South Dakota	238	200	9	27	2
Total	14,154	6,533	4,244	2,145	1,232

* Includes 20 readmissions.

ELIZABETH MILBANK ANDERSON

IN the death of Elizabeth Milbank Anderson the National Committee for Mental Hygiene has lost a member whose generous material support was accompanied by real companionship and sympathetic understanding of the complex human problems with which this organization has to deal. She saw that the protection of mental health rarely had a place in the broad movements for hygiene and sanitation that received her aid, and that the resources of science and humanity which she helped so often to bring to the assistance of the sick rarely, if ever, reached those who suffer from mental diseases. It touched her heart to see the welfare of so large a class of sick people uninfluenced by the generosity of those who give to hospitals, clinics, and nursing service, and her keen mind saw how illogical it was that a whole field of health should lie outside the rapidly spreading public-health effort of the times simply through the survival of prejudices that arose in the darkness of the past.

In 1915, when Mrs. Anderson came to the aid of the National Committee for Mental Hygiene at a critical time, there was but little assurance that this new organization would achieve any considerable measure of success in the tasks that it had hopefully set for itself. It is significant of her willingness to help the weak as well as the strong that she was not deterred by the chance of failure. That success quickly followed, and a new popular point of view regarding mental disease gained ground in time to influence profoundly the treatment of mentally disabled American soldiers during the war, was a source of the greatest pleasure to the wise, kind woman who had taken a chance when caution might have dictated another course.

Elsewhere are recorded the contributions of interest, personal encouragement, sound advice, and generous financial assistance that Mrs. Anderson gave during her life and insured for the years to come to other organizations for the promotion of human welfare and the relief of human suffering. The diversity of their fields of work testifies to the breadth of her humanitarian interests. It is desired to record here only the sorrow of the officers and members of this association over the termination of her useful life, the inspiration that her memory furnishes for the future, and the great debt which those upon whom the shadow of mental illness rests or over whom it hovers owe to one whose benevolence passed formal bounds in zeal to find new opportunities for helpfulness.

ABSTRACTS

EXPERT TESTIMONY IN CRIMINAL PROCEDURE INVOLVING THE QUESTION OF THE MENTAL STATE OF THE DEFENDANT. By William A. White, M.D. *Journal of Criminal Law and Criminology,* 11: 499-511, February, 1921.

The disrepute into which expert medical testimony in criminal cases has fallen is, in Dr. White's opinion, to be traced to one main cause—the fact that the present method of criminal procedure is not what it pretends to be. The expert witness is hired and paid by one side in an essentially partisan contest, for that is what the trial of a criminal case before a jury undeniably is at the present time; he represents that side and all his interests are on that side, yet he is asked to preserve a strictly nonpartisan attitude and to answer all questions fairly and impartially. This demand is psychologically an impossible one to meet. "The witness generally errs in one of two directions—either he is distinctly partisan or, because of being in fear that he will be partisan, he leans over so far backward that he unnecessarily injures the cause which he represents. The former of the two errors is naturally the more frequent, but it is not an error born of dishonesty, for, far from having any intent to deceive, the witness honestly tries his best, in the great majority of cases, to present his views fairly, but it is an error born of a natural weakness of human nature as it fails before an impossible task." This partisanship—"which does, as a matter of fact, exist, no matter how strongly it may be denied"—is, Dr. White believes, at the root of the public's antagonistic attitude toward expert testimony; but it is not a thing for which the medical man should be blamed—it is the result of a wrong system, a system not of his making.

The following statute, drawn up by a committee of the American Institute of Criminal Law and Criminology, and adopted by the institute without a dissenting voice, is offered as a suggestion for the correcting of the method of procedure as it now exists:

"SECTION 1. Where the existence of mental disease or derangement on the part of any person becomes an issue in the trial of a case, the judge of the trial court may summon one or more disinterested qualified experts, not exceeding three, to testify at the trial. In case the judge shall issue the summons before the trial is begun, he shall notify counsel for both parties of the witnesses so summoned. Upon the trial of the case, the witnesses summoned by the court may be cross-examined by counsel for both parties in the case. Such summoning of witnesses by the court shall not preclude either party from using other expert witnesses at the trial.

"SECTION 2. In criminal cases, no testimony regarding the mental condition of the accused shall be received from witnesses summoned by the accused until the expert witnesses summoned by the prosecution have been given an opportunity to examine the accused.

"SECTION 3. Whenever in the trial of a criminal case the existence of mental disease on the part of the accused, either at the time of the trial or at the time of the commission of the alleged wrongful act, becomes an issue in the case, the judge of the court before which the accused is to be tried or is being tried shall commit the accused to the state hospital for the insane, to be detained there for purposes of observation until further order of court. The court shall direct the superintendent of the hospital to permit all the expert witnesses summoned in the case to have free access to the accused for purposes of observation. The court may also direct the chief physician of the hospital to prepare a report regarding the mental condition of the accused. This report may be introduced in evidence at the trial under oath of said chief physician, who may be cross-examined regarding the report by counsel for both sides.

"SECTION 4. Each expert witness may prepare a written report upon the mental condition of the person in question, and such report may be read by the witness at the trial. If the witness presenting the report was called by one of the opposing parties, he may be cross-examined regarding his report by counsel for the other party. If the witness was summoned by the court, he may be cross-examined regarding his report by counsel for both parties.

"SECTION 5. Where expert witnesses have examined the person whose mental condition is an element in the case, they may consult with or without the direction of court, and if possible prepare a joint report to be introduced at the trial."

The adoption of such a statute as this, however, would by no means solve all the difficulties connected with the question of criminal procedure and expert medical testimony. "In the first place the law as it exists on the statute books is still essentially a law of revenge;" it is concerned with the crime rather than with the criminal, with conduct as of this or that type rather than as the reaction of a particular individual to stimuli without and within. Modern science, on the other hand, is concerned with correcting rather than with punishing; it recognizes the fact that crime cannot be considered apart from the individual criminal, or dealt with intelligently except as the result of that particular individual's maladjustment to society. "If the individual be studied carefully, it can always be seen how a given crime issues logically out of the antecedents in that individual's life. The unfolding of the individual's character in relation to the total situation in which the crime occurred makes it at once understandable. In this day and age, the revenge attitude of society against the criminal is unintelligent. The attitude that should be assumed and that science is forcing upon the courts and the legislatures is the attitude of endeavoring to deal efficiently with the problems that the individual presents, with the deep conviction that arbitrary terms of imprisonment and capital punishment are not the last words in serving this end."

From this general criticism of the existing system of legal procedure, Dr. White passes on to a discussion of three particular points in which he feels it to be out of accord with modern scientific thought. There is, first, the supposition that judge and jury are unprejudiced—"able to consider the evidence solely upon its merits and arrive at conclusions free from personal bias." To students of present-day psychology, it is evident that this is impossible, since such a thing as an unprejudiced individual does not exist. "The reason why I make this statement so definitely," Dr. White explains, "is because it is generally conceded by those engaged in the study of psychology that mental actions are necessarily conditioned by all that has gone into the composition of the fabric of the mind, whether all those elements which for the time being are operative are present in consciousness or not. In other words, an opinion is the outcome of the whole tendency of the individual as it has been built up during his lifetime, and whether he thinks it or not, he is swayed at every point by these ingrained tendencies.

"Every human being must, therefore, of necessity approach every problem with the natural bias of his own personality make-up, based as it is upon the totality of his hereditary tendencies, his upbringing, and his past experiences. . . . Prejudice in this sense is an ineradicable element of the human mind, and the best that can be done is to attempt to reduce it to a minimum. The medical expert who is aware of the true state of affairs is a safer witness than one who is blind to its possibilities, and the same may be said of a judge or in fact any one searching for the truth in the tangled network of human motives. The law should face this fact squarely and no longer refuse to see it. The procedure in attempting to get at the facts would be made simpler by so doing."

The hypothetical question, again, is a psychological absurdity. It is based upon the theory that it is the jury's function, not the expert's, to decide whether the defendant is or is not of sound mind. There does not seem to be any particular reason why the jury should not hear the expert's opinion of the mental condition of the defendant, and as a matter of fact the hypothetical question is a mere quibble. The jury knows and every one else knows that when the expert answers the question, he is expressing his opinion of the defendant. It would, indeed, be psychologically impossible for him to consider the facts included in the hypothetical question by themselves, apart from his knowledge of the defendant.

The question of the responsibility of the defendant is another unscientific concept of law. Responsibility is regarded as a definite possession, which the criminal is supposed either to have or not to have, much as he might possess or not possess certain real estate or some other tangible asset. "Such ways of dealing with human beings show an absolute lack of understanding of the principles of conduct, and belong to the same stage of development as the spirit of revenge. To conceive that an individual is either absolutely responsible or absolutely irresponsible is to fly in the face of perfectly patent facts that are in everybody's individual experience, and is comparable only to such beliefs of the middle ages as that a person is possessed of a devil or is not possessed of a devil and is therefore a free moral agent." The question of responsibility, Dr. White believes, is determined by the jury by the process of making up their minds, from the facts presented to them, whether they think the defendant ought to be punished or not; if they think that he ought to be punished, they conclude that he was responsible and therefore guilty. Responsibility is thus something that exists in the minds of the jury rather than in the mind of the defendant.

The function of the expert should be to bring his specialized knowledge to the service of the court. He should be placed in as impersonal an attitude toward the issue as the judge and jury, and he should have the opportunity to set forth a coherent, connected account of the defendant, analyzing his character make-up, showing how he came to be the manner of man he is, and explaining the crime in relation to this setting. With such a complete picture before them, the jurors can pass intelligently upon the issue.

A PSYCHOLOGICAL STUDY OF MOTION PICTURES IN RELATION TO VENEREAL-DISEASE CAMPAIGNS. By Karl S. Lashley, Ph.D., and John B. Watson Ph.D. *Social Hygiene,* 7:181-219, April, 1921.

This paper is a condensed form[1] of the report of an investigation conducted by the Psychological Laboratory of Johns Hopkins University for the United States Interdepartmental Social Hygiene Board as to the effectiveness of certain motion-picture films used in venereal-disease campaigns and the value of motion pictures in sex-education work in general. The study was made by the authors under the general supervision of an advisory board consisting of Dr. Adolf Meyer, Dr. Shepherd I. Franz, and Professor Robert S. Woodworth.[2]

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[1] The complete report is being published as a monograph. Any one interested may obtain further information by addressing the American Social Hygiene Association, 370 Seventh Avenue, New York City.

The aim of popular education in sex hygiene is twofold: (1) to increase popular knowledge of the facts with regard to sexual physiology and psychology and (2) to arouse an emotional attitude that will result in the actual application of the information received, since it is doubtful whether information unaccompanied by emotional factors will have any significant effect upon behavior. The problem of the authors, therefore, was to determine both the informational and the emotional effects of the pictures being shown to the public on the subject of sex hygiene and also, if possible, the transitory and permanent effects that they produce upon the behavior of those who see them.

It was decided to concentrate the investigation upon one film, and *Fit to Win,* one of the films used in army camps in the campaign against venereal disease and later revised for civilian use, was selected as the best adapted to the purposes of the investigation. It is also the one that seems to be provocative of most of the criticism directed against sex-hygiene films, emphasizing as it does both the danger of disease and the value of prophylaxis without stressing the moral aspects of the problem, using language that is frequently crude, and showing certain scenes that are open to the charge of pornography. Study of it, therefore, should reveal most of the bad effects that have been laid at the door of this and other sex films.

The following are the main points that *Fit to Win* is designed to teach: (1) that continence is in no way injurious to health, but that the continent man is physically superior to the incontinent; (2) that seminal emissions are not harmful unless occurring more frequently than twice weekly; (3) that venereal diseases are very serious and may lead to total disability unless given careful and long-continued treatment; (4) that venereal diseases are the result of infection by microörganisms; (5) that syphilis is communicable by contact or by the use of toilet articles of an infected person; (6) that the use of prophylaxis, after exposure, is advisable, but must be prompt and careful to be effective; (7) that both syphilis and gonorrhea require persistent and long-continued treatment; (8) that the government maintains recreation rooms for soldiers and that various forms of wholesome recreation may serve as a substitute for the bawdy house; (9) that venereal infections constitute a serious loss to the government and a severe handicap in the prosecution of the war; (10) that doctors who advertise quick cures for venereal diseases are unreliable.

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[2] For a special phase of this study see *A Consensus of Medical Opinion Upon Questions Relating to Sex Education and Venereal-Disease Campaigns,* by John B. Watson and K. S. Lashley. MENTAL HYGIENE, Vol. IV, pp. 769-847, October 1920

The picture makes also a number of emotional appeals: (1) the influence of a sweetheart in keeping a man continent is shown; (2) the men are urged to remain continent from patriotic motives; (3) the infected men are shown in contrast to the fit in a way to touch the pride of the men who see the picture; (4) some of the scenes appeal to parental and filial affection; and (5) others are calculated to arouse fear of infection. The possibility that the picture might produce harmful emotional reactions—such as morbid fear of infection amounting to a phobia, excessive interest or curiosity about sex matters, or sex antagonism on the part of women toward men in general—had also to be taken in consideration.

The investigation was conducted by means of questionnaires, observation of the audiences, personal interviews, and follow-up work carried on with the coöperation of social workers, physicians, and others in the various places in which the picture was shown.

The audiences varied widely in education, social tradition, and economic standards. They included a medical group; a clerical and executive group; a group made up of the members of a women's social and literary club; a mixed audience of both sexes, fully half of them boys and girls under seventeen, gathered at a free performance in a village in Pennsylvania; a group of car men; a group of sailors, most of them ordinary seamen; and a group of soldiers, mostly enlisted men. Also, four performances—one each for men and women, white and colored—were given in each of two towns of about 8,000 inhabitants on the Eastern Shore of Maryland. Altogether, during the course of the experiment, between 4,800 and 5,000 persons saw the picture; 1,230 questionnaires were obtained; nearly 100 men were personally interviewed; and verbal reports on the after effects of the picture were received from 73 voluntary field workers whose observations extended for periods up to six months after the performances. The authors feel that the data obtained may be looked upon as a fair sample of the effects that the picture might produce in any community.

From these data the authors draw the following conclusions with regard (1) to the effectiveness of such films as *Fit to Win* in venereal-disease campaigns and (2) to the value of the motion-picture method in general sex-education work:

Fit to Win is moderately successful in conveying information. The questionnaires showed that at least 50 per cent of those who were previously ignorant or misinformed acquired from the picture some definite information on each of the ten more important topics dealt with, this raising the average level of information to 70 per cent with a fairly accurate knowledge of each topic. "Naturally the amount of information acquired varied with the space devoted to the topic and the clearness and emphasis with which it was presented. Practically all learned the ready communicability of venereal disease by contact; relatively few the distinction between syphilis and gonorrhea in this respect. And so with other topics. Only where the information given was simple, clear, and without the assumption of preëxisting knowledge did any large percentage of the audience grasp it."

As to the emotional effects of the picture and its after effects, the authors state: "There is clear evidence that only in rare cases is any sexual excitement produced and there is no danger whatever that the picture will lead to immediate incontinence. On the contrary, according to the reports of men, it has some inhibitory influence, although this is not strong enough to withstand any strong temptation. No sex antagonism is produced either in men or women. There is no evidence that any dangerous interest in sex is aroused, even in children, but our data on this point are limited to one group of boys and are scarcely adequate. With audiences limited to one sex there has been no indication of emotional shock or serious offense at even the crudest parts of the picture.

"With men the film arouses some fear of venereal infection and a resultant determination to be careful, chiefly by avoiding prostitutes. There is little indication of any other constructive emotional influence. Among mature women sympathy for the innocently infected is more frequently aroused, with a desire to guarantee better education for young men and women. In neither sex does the fear of disease seem strong enough to induce morbid reactions.

"The attitude toward the film aroused in both men and women is one of approval. Ninety-five per cent of the men and 100 per cent of the women studied believed that the picture would be beneficial and that it should be shown to the general public. More than half of the men believed that it should not be shown to women (sisters or sweethearts), but all of the women believed that it should be shown even to young girls.

"The picture is not adapted for showing to mixed audiences under any conditions where the men and women may meet immediately after the performances. In one such experiment we found that inhibitions were broken down among the younger people and that comments bordering on the indecent were passed between the boys and girls. This seemed to have been the result of a temporary relaxation produced by the picture plus the knowledge that each had seen the picture and been somewhat embarrassed before the other. Where the picture was shown to one sex only, we could find no evidence of flippant attitude in any part of the audience.

"Only two important after effects upon behavior have been demonstrated. A few individuals are stimulated to active interest in sex-hygiene campaigns. They seek to get repeated showings of the film or to obtain pamphlets and other propaganda material. They seem to be, for the most part, individuals who are already interested in the problem and who see in the performance an opening wedge for further work. A small number of men, in the belief that they may be infected, seek medical advice. The number of these that we were able to trace amounts to about 1 per cent of the total male audience.

"No lasting effects were found. The retention tests show that the main facts were remembered very well for periods up to five months, but there is no indication that behavior is modified significantly. The picture does not reduce the exposure rate of men who see it or make them more careful in the use of prophylaxis, except possibly for a few days. Nor did ill effects seem to persist to any great extent. Interest dies out rapidly, and the picture seems to be forgotten as quickly as the average motion picture devised solely for amusement.

"The effectiveness of the picture thus seems to be limited to conveying information concerning venereal diseases. While the dramatic portions of it do no active harm, it is doubtful if they contribute in any way to its educative value or add to the interest which the facts presented have for the audience. Indirectly, they cut down the space that can be devoted to informational topics and limit the informative value of the picture. The need for more elementary and comprehensive instruction than is included in *Fit to Win* leads us to believe that the development of more complete and scientifically accurate expository films along the lines already begun in the lecture films of the American Social Hygiene Association will prove more effective and profitable than will an attempt to continue the use of the dramatic method of presentation."

This judgment as to the value of the dramatic method of presenting material applies also to work in sex education. Here, too, the treatment should be simple, expository, and kept as nearly as possible on a purely scientific plane. "The use of popular instead of scientific names is inadvisable, since the meaning of the latter is almost always acquired from the context, while the former may be taken as obscenely humorous." The authors feel, however, that motion pictures are not the best method of instruction in the field in which sex education is most vital: "The one place where we can hope to effect permanent control of sexual conduct through education is in adolescence. Films of the type of ***Fit to Win*** are not adapted for use at this age, and it is doubtful if any motion picture will ever be as satisfactory here as other educational methods, since there is need for adaptation of the material to the individual requirements of the youth. The films seem particularly effective, however, in arousing in adults an appreciation of the need for education and control of sex in adolescence. The most promising sphere of usefulness for motion pictures would seem, therefore, to be in building up a public opinion that will favor the utilization of other educational methods which can be better adapted to the individual needs of children and adolescents."

ALCOHOL AND SYPHILIS AS CAUSES OF MENTAL DISEASE. By George H. Kirby, M.D. *The Journal of The American Medical Association,* 76:1062-66, April 16, 1921.

Statistics published in recent years both in Europe and in America led to the generally accepted conclusion that alcohol and syphilis were the causes of from one-fifth to one-fourth of all cases of mental disease that required hospital treatment. Among male patients, the proportion was even higher—from one-fourth to one-third. Within the last decade or so, however, there have been certain developments in social life and in medical science that may be expected to have a marked effect upon the prevalency and potency of these two outstanding causes of mental disease. These developments are the reaction against alcohol—which has found concrete expression in an ever-increasing application of local option, in the passage of state-wide restrictive laws, and finally in the adoption of the prohibition amendment to the Constitution—and the introduction of new methods of detecting and treating syphilis, notably the use of arsphenamin in treatment, combined with the spread of information with regard to that disease among the general public. This paper is a study of the results already produced by these new influences as indicated by certain figures with regard to alcoholism, alcoholic psychoses, and paresis in the state of New York during the years 1909-1920.

The effect of the reaction against alcohol is strikingly illustrated by the following table (Table 1) which shows "the percentage distribution by years of 77,334 cases of alcoholism (exclusive of psychoses) treated in the Bellevue alcoholic wards. The comparison is made with the total number of patients treated annually in Bellevue Hospital, exclusive of cases of accident and injury."

TABLE 1.—NUMBER AND PERCENTAGE OF CASES OF ALCOHOLISM AMONG TOTAL NUMBER OF PATIENTS TREATED AT BELLEVUE HOSPITAL

	Total No. of Patients Treated in Bellevue Hospital*	Number of Cases of Alcoholism**	Per Cent of Alcoholism
1909.	35,295	9,607	27.2
1910.	33,677	10,691	31.7
1911.	30,151	8,348	27.7
1912.	32,541	8,000	24.6
1913.	32,712	7,732	23.6
1914.	34,073	6,869	20.1
1915.	43,111	6,157	14.3
1916.	40,562	7,086	17.5
1917.	40,605	5,849	14.4
1918.	37,222	2,525	6.7
1919.	33,826	2,469	7.3
1920.	34,034	2,001	5.8
Total.	427,809	77,334	

* Exclusive of traumatisms.

** Cases diagnosed acute and chronic alcoholism, the definite alcoholic psychoses, are not included.

"This table shows a remarkable fall from the high point of 1910, when 31.7 per cent of all cases passing through Bellevue Hospital were diagnosed as 'alcoholism,' to the low point in 1920, when only 5.8 per cent were so diagnosed. . . . The continuous decrease in the ratio of alcoholic cases is all the more significant when we take into consideration the fact that the population of New York City has been steadily increasing and that there has been apparently no important shifting of alcoholics to other hospitals or institutions for treatment."

Chart 1 is a graphic representation of the main points of interest in Table 1. "The slight upward turn of the curve in 1919 is due to a relative increase of cases of alcoholism, the result of a falling off of the total general admissions to Bellevue Hospital. As a matter of fact, the actual number of alcoholics in 1919, as shown in Table 1, was less than in the preceding year, and the number for 1920 is the lowest yet reached." The noticeable rise in 1916—which has a corresponding rise in the curve for alcoholic psychoses shown in Chart 2—was probably largely due to the tension and unrest of the period immediately preceding the entrance of the United States into the World War. As soon as that issue had been definitely settled, the decline both in cases of alcoholism and in alcoholic psychoses set in again and has continued ever since.

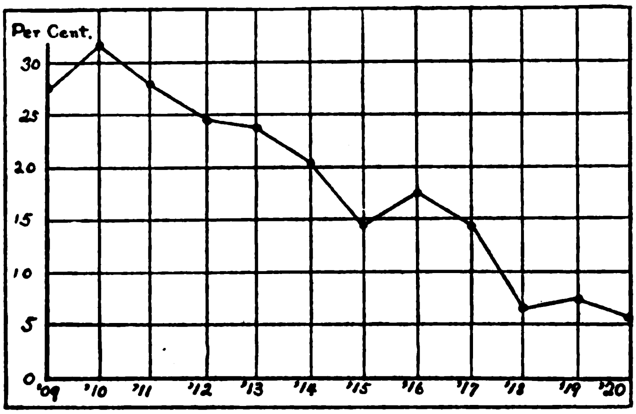

Chart 1.—Annual percentage of cases diagnosed as alcoholism among total patients treated at Bellevue Hospital

Table 2 shows the percentage distribution by years of the cases of alcoholic psychoses admitted to the New York state hospitals. Comparison is made with the total annual first admissions to these hospitals.

TABLE 2.—NUMBER AND PERCENTAGE OF ALCOHOLIC PSYCHOSES AMONG FIRST ADMISSIONS IN NEW YORK STATE HOSPITALS

Year	Total First Admissions	Alcoholic Psychoses	Per Cent of Alcoholic Psychoses
1909	5,222	561	10.7
1910	5,564	583	10.5
1911	5,700	591	10.4
1912	5,742	565	9.8
1913	6,061	572	9.4
1914	6,265	464	7.4
1915	6,204	345	5.6
1916	4,903*	297*	6.1
1917	6,877	594	8.6
1918	6,797	354	5.2
1919	6,791	269	3.9
1920	6,573	122	1.8
Total	72,699	5,317	

* Figures for a period of nine months only, owing to change in hospital year.

"The accuracy and significance of these data are enhanced by the fact that the figures include only *first* admissions. . . . By thus eliminating readmissions we get as accurate a record as possible of the number of fresh psychoses developing each year in the community."

Chart 2 represents graphically the ratios contained in Table 2. To meet the possible argument that the decline in the number of cases of alcoholic psychosis reported by the hospitals might be partly due to a change in diagnostic attitude, a separate curve—the lower curve in Chart 2—was plotted for the Korsakoff cases, since "in that type, with its characteristic physical and mental picture, the margin of diagnostic error would certainly be reduced to a minimum." The fact that the Korsakoff curve follows in a remarkable way the curve of the total alcoholic psychoses confirms the opinion "that there has been a definite reduction in cases incontestably of alcoholic origin."

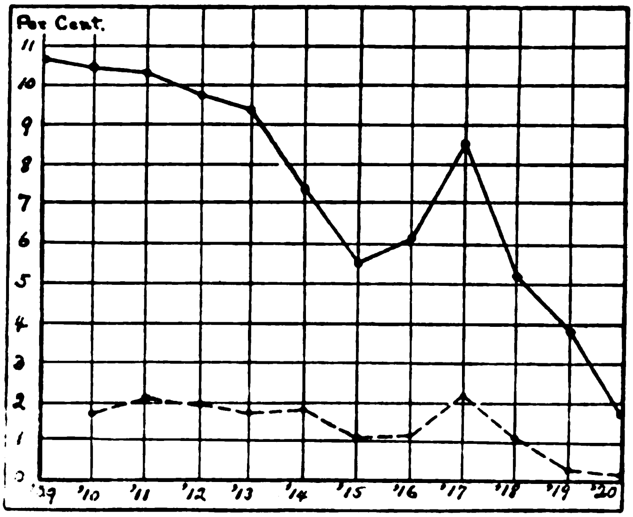

Chart 2.—Annual percentage of alcoholic psychoses among first admissions to New York state hospitals: solid line, total alcoholic psychoses; broken line, Korsakoff's psychosis

The statement occasionally published that alcoholism has been increased by prohibition has no basis in fact. There have been within recent months some fluctuations in the number of cases admitted to alcoholic wards in large cities, but such increases as have been reported may be regarded as merely temporary and in any case fall far below the figures of former years. "The indications are that prohibition will result in a still further reduction of the number of cases of alcoholism and alcoholic psychosis." There have been no signs, either, that the alcoholic psychoses are being replaced by other psychotic types, such as the drug psychoses. As shown in Table 2, the number of first admissions to the state hospitals has declined in the last five years, probably largely as a result of the decline in alcoholic psychoses. There has been a decrease in the number of drug psychoses also.

It is more difficult to answer the question whether the new developments of the last ten or fifteen years have had any appreciable effect upon the number of cases of neurosyphilis. It may be too soon to look for results, especially from the new methods of treatment, since neurosyphilitic lesions are not usually brought to attention until from five to fifteen years after the initial infection. Almost the only data available for study at present are those relating to the neurosyphilitic cases admitted to the state hospitals, especially the cases of paresis.

Table 3 shows the percentage distribution by years of the cases of paresis among first admissions to the New York State Hospitals for mental disease for the period 1909-1920. The comparison is made with the total annual first admissions to the state hospitals.

TABLE 3.—NUMBER AND PERCENTAGE OF CASES OF PARESIS AMONG FIRST ADMISSIONS IN NEW YORK STATE HOSPITALS

Year	Total Number of First Admissions	Cases of Paresis	Per Cent of Paresis
1909.	5,222	658	12.6
1910.	4,312*	520*	12.0
1911.	5,700	758	13.3
1912.	5,742	719	12.5
1913.	6,061	768	12.7
1914.	6,265	744	12.4
1915.	6,204	814	13.1
1916.	4,903**	640**	13.1
1917.	6,877	866	12.6
1918.	6,797	913	13.4
1919.	6,791	880	12.9
1920.	6,573	820	12.5
Total.	71,447	9,100	

* Admissions of one hospital not included, owing to error in reporting cases.
** Figures for nine months' period only, owing to change in hospital year.

This table shows that there has been little variation in the admission rate for paresis during the last twelve years; the fluctuations have been within narrow limits—a little above or a little below 13 per cent. The upper curve in Chart 3 represents this graphically. This curve shows, however, that there has been a slight decline during the last two years—from 13.4 per cent in 1918 to 12.5 per cent in 1920. Dr. Kirby is "inclined to attach some significance to this indicated decline especially when the recent census figures are utilized and the rate of paresis per hundred thousand of the general population is computed. This computation gives, according to statisticians, a truer index of the incidence of a disease than does a ratio based on percentage of admissions."

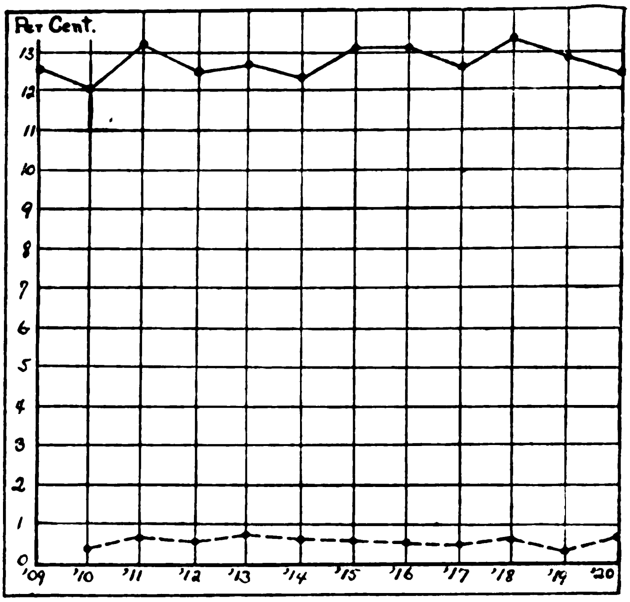

Chart 3.—Annual percentage of paresis and cerebral syphilis among first admissions to New York state hospitals: solid line, general paresis; broken line, cerebral syphilis

TABLE 4.—RATE PER 100,000 OF GENERAL POPULATION OF NEW YORK STATE OF ALCOHOLIC PSYCHOSES AND PARESIS

Year	All Psychoses	Alcoholic Psychoses	Paresis
1913	64.1	6.0	8.1
1914	65.4	4.8	8.1
1915	64.0	3.6	8.4
1916	66.5	4.0	8.7
1917	69.0	6.0	8.7
1918	67.3	3.5	9.0
1919	66.3	2.6	8.6
1920	63.3	1.2	7.9

"Reference to Table 4 shows that the rate for paresis per hundred thousand of the population of New York State was quite uniform, with, however, a slight upward tendency from 1913 to 1917; in 1918, a high rate was reached, the highest on record. Since then, however, there has been a decline, so that in 1920 we have a lower rate for paresis than at any time in the last eight years. Moreover, by referring to Table 3 we find that the actual number of cases of paresis admitted to the hospitals in 1920 was less than in 1919, considerably less than in 1918, and also smaller than in 1917. This reduction in actual numbers may perhaps be all the more significant when we consider the steady increase of the population of New York State. The suggestion has been made that the indicated decline in the number of syphilitic psychoses might be due to the more frequent retention than formerly of these cases for treatment in general hospitals. If this is actually occurring, it would hardly modify greatly the figures for the psychotic group of the entire state over a period of years unless real curative results were being obtained."

The lower curve in Chart 3 represents another, much smaller group of neurosyphilitic cases—the so-called cerebral-syphilis cases with psychosis. This group is, however, too small to be used for statistical purposes, the average number admitted during the last ten years being only 43 a year.

Dr. Kirby concludes: "From the standpoint of mental hygiene, the situation may be regarded as encouraging. A notable advance has been made in the direction of controlling one of the outstanding causes of mental disease—namely, alcoholism—and as regards a second great cause of mental disease—namely, syphilis—there are indications that education, prophylaxis, and improved methods of treatment are beginning to yield some results, as yet slight, to be sure, but nevertheless sufficient to be considered a sign of progress."

BOOK REVIEWS

FOUNDATIONS OF PSYCHIATRY. By William A. White, M.D. New York and Washington: Nervous and Mental Disease Publishing Company, 1921. (Monograph No. 32.) 136 p.

This monograph contains nine chapters with a felicitous introduction by Dr. Stewart Paton. The main text deals with: *The Unity of the Organism: The Biological Point of View—Integration—Structuralization—Individuation; The Dynamics of the Organism: The Canon of Physiology (The Conflict)—Ambivalency; The Stratification of the Organism: The Physiological, the Psychological, and the Sociological Level; The Region of Psychopathology; The Nature of the Neuroses and the Psychoses; Therapeutics: Action—Objectification—Transference—Resymbolization; The Social Problem: Elevation—Rationalization—Sublimation—The Socialization of Strivings.*

White has essayed a rather unique task. It is no less than to impress upon the medical and the lay reader the importance of the psycho-biologic view in order that the essential foundations of psychiatry may be grasped. His task is doubly difficult. In the first place, almost every medical student has been trained in the formal, academic psychology in his college preparatory course, and this manner of approach, until recently, has been to study the mind as composed of so many separate processes or faculties—will, memory, attention, etc. No attempt has been made to study the mind as a unit—as a feeling, knowing organism. Hence academic psychology leaves one cold and indifferent as to its practical uses in everyday life. Formal psychology has made little attempt to study the mind as a synthetic, integrated organism. Secondly, the average medical student is plunged still further into the analytic study of the body and mind piecemeal. Near the end of his medical course, he is suddenly required to view the body and mind as an integrated individual or personality, a living and acting organism. Some few can accomplish this right-about-face in method and gain an entirely new perspective. The majority, however, are left floundering in an effort to view the maladapted mental processes as so many defects in kidney and liver function. It is true that the organic processes do play a rôle in the induction of the psychoses, but, once initiated, the nervous disorder takes on a pattern plan according to mental laws quite distinct from the cause that incited it. The inference from the present method of study is that one has but to add up all the organismal activities *in toto* to gain a proper conception of the body as a whole. The author points out how fallacious this conception is inasmuch as new and unpredictable functions come into being in the successive evolutional levels of development. He logically argues that the order of study ought to be reversed—the integrated, synthesized human organism first, and afterward the analytical and component parts. If such a biologic approach may result in the student's becoming concerned with the minute study of the structure and mehanism of the component parts, this does not lessen the force of the writer's contention. For a long time White has given much attention to the theory of the so-called stratification of the organism, a sort of recrudescence of the Hughlings Jackson concept. While this is a rather mechanistic view and liable to do violence to the facts, it is a manner of approach not without distinct explanatory advantages to one unacquainted with physio-psychology.

This work of White's is a thoroughly readable exposition of a difficult subject, and his digest of the literature employed in his text yields not a little supportive influence to an up-to-date account of the foundations of psychiatry. It can be thoroughly recommended to all interested in this subject. The latter half of the book is mainly a restatement of our present psychoanalytic knowledge of the neuroses and psychoses and their treatment.

L. PIERCE CLARK.

New York City.

THE BEHAVIOR OF CROWDS. By Everett Dean Martin. New York: Harper and Brothers, 1920. 312 p.

Mr. Martin's book is an important contribution to the theory of crowd psychology. His elaboration of the rôle of unconscious motives and wish fancies in crowd behavior gives us a new and promising hypothesis. It remains for subsequent observers to authenticate or modify his hypothesis as additional evidence is gathered.

After touching upon some social problems of to-day in Chapter 1, the author considers in Chapter 2 how crowds are formed. The term "crowd" refers to a state of mind, a phenomenon to be classed with dreams, delusions, etc., because like them it is a device for gaining an escape from the hard realities of life. In everyday life social conventions repress and inhibit, whereas in the crowd the immediate social environment pulls in the direction of the unconscious desire. In a crowd, therefore, one can indulge in acting on desires ordinarily inhibited, as, for example, in a lynching. Chapter 3 reviews the psychology of unconscious motivation as revealed in crowd action. Chapter 4 describes the egoism of crowd mind. In a crowd the individual transfers his repressed self-feeling to the idea of the crowd and can then exalt himself. For example, the crowd insists on being flattered. The fanatic is a crowd man, since the evil he struggles against is the projection of his own inner conflict. The crowd is shown to be a creature of hate in Chapter 5. The crowd has delusions of persecution, ideas of self-pity, and its murder wish appears in consciousness whenever the unconscious can fabricate such a defense mechanism as will provide it with the fiction of moral justification. This analysis is applied to lynching, Americanization propaganda, patriotic crowds, etc., with considerable skill.

One dissimilarity between crowd mind and the true psychosis is that in the latter the inadequately repressed wish is disguised by some mechanism, whereas in the former the repressed impulse is permitted to escape because the immediate social environment which is ordinarily a check relaxes repression.

The absolutism of the crowd mind is analyzed in Chapter 6. Just as rationalism and idealism in philosophy provide certain persons with a system of ideas in which they may take refuge from reality, so the radical crowd substitutes for the shifting phenomena of our empirical world a closed system of ideas which consists of easy generalizations and satisfying abstractions. The author does not attempt to reconcile this view with the experience of prison reform, in which it has been shown that personality is enlarged and strengthened when loyalty is transferred from the person (the concrete), as under the honor system, to a group (the abstract), as under self-government.

Revolutionary crowds (Chapter 7) are chiefly devices for sustaining the self-feeling of their members and only secondarily instruments for dealing with complex social situations. Revolution is the phenomenon of two crowd minds in conflict—a dominant crowd and an under crowd. Revolutionary propaganda is a symptom of disintegration of the system of control by the dominant crowd. Revolutionary crowds are motivated by the dream of an ideal society. The fulfillment of this dream will bring the millenium, but mere contemplation of it gives an escape from reality.

To the student of crowd psychology who reads this book, the question arises: Does crowd mind in its heightened state arise apart from actual gatherings of people in physical contact? Mr. Martin seems to think so, for he speaks of permanent crowds. This question is an important once, since social psychologists have heretofore pointed out that the heightened suggestibility and weakened inhibitions of the crowd are connected with bodily conditions of fatigue and irritation resulting from the close contact of its members. If any differences exist between crowd mind and the formation of the crowd mob, Mr.

Martin does not make clear whether he considers the difference to be one of degree or of kind. Ross distinguishes the public from the crowd on the basis of the factor of actual assemblage. This question is an interesting one, since the nature of the answer to it would help to determine whether the biological function of the crowd—its service as a defense mechanism—gives it a strong degree of survival value.

In Chapter 8 the author discusses the fruits of revolution and new crowd tyrannies for old. The reaction and disillusionment that come after revolution require new defenses to be erected against the inevitable disclosure of the fact that people are not behaving as if the Kingdom of Heaven had really come.

Chapter 9 considers freedom and government by crowds. Chapter 10 discusses education as a cure for crowd mind. It is shown that traditional education confirms crowd mind since it really does little more than systematize crowd thinking. To be a cure of crowd-mindedness, education must begin with the individual and that individual must be "myself." It is through education by doing and also by the training of the critical faculty that immunity from crowd thinking is to be had.

F. STUART CHAPIN.

Smith College.

CHARACTER TRAINING IN CHILDHOOD. By Mary S. Haviland. Boston: Small, Maynard, and Company, 1921. 296 p.

This is a book full of common sense and one that young mothers will find well worth several readings. The thought is clearly expressed, the case illustrations are interesting, and the posters are "good advertising." It is unfortunate, however, that the author has not taken into consideration the fact, so clearly demonstrated in studies of children, that children's subjective feelings of inferiority to others or their feelings of guilt about something are frequently the determinants of conduct disorders.

The author deals only with those inherent characteristics which are from an ethical point of view commendable and right; and she dismisses all the other inherent traits with the statement, "Unfortunately, there is a perverse streak in human nature that makes most of us hanker after unwholesome things." Again she says, "Just so the baby brain may acquire the false idea that selfishness, temper, and other ugly traits pay, and in later years this idea can be altered only by a painful wrenching and breaking process that means infinite trouble and suffering for both parent and child." A reader will have to suppose that she does not deal with such things as hate, jealousy, fear, and sex emotions in children. She ignores them in her book. She presents many *credenda* for children, but she omits the *agenda* on the part of the children.

She takes the behaviorists' point of view in describing the physical behavior of children, but she in no case tells of their subjective mental behavior. In two instances, however, children do actually tell the secret, but the author apparently fails to appreciate the import. In one case, seven-year-old Helen (page 85) was troublesomely dependent until Miss Haviland answered her wistful question, "Babies are much cunninger than little girls, aren't they?" by assuring her of recognition and attention as a little girl such as she would not get if she were a baby. Helen had a feeling of inferiority because she was not "cunning," and undoubtedly had to use the mechanism of dependence in order to get attention.

A second instance is that of Jimmie, aged twelve (page 163). His mother could not train Jimmie to make his bed satisfactorily. Finally his uncle undertook the task. Jimmie told him that he had thought only girls made beds, but after he learned that bed making was compatible with manliness, he was willing to make his own bed properly. But probably his uncle, his mother, and the author did not appreciate that it was an idea of inferiority on Jimmie's part that he was fighting. In his own mind, Jimmie did not want to feel inferior to his standard of what boys ought to do. I think it is likely that Jimmie had another feeling of inferiority antedating this, and that although he may have made his bed after his uncle left, his mother did not find him perfect. How much simpler it would have been all around if, instead of Helen's being trained to be independent, and Jimmie's being trained to make beds, according to adult standards, Helen's mother had asked her *why* she wanted to to be dependent or *why* she didn't want to grow up, and Jimmie had been given a chance to tell *why* he did not want to make beds and to overcome his feelings of not being manly.

In the rest of the book the reader is given no idea of the reason for difficulties arising from children's having to meet the expectations of their trainers. For example, little Julia, the colored girl, was obstinate about something and refused an explanation of her conduct. Balked, Miss Haviland said that since Julia acted like a baby, she would have to sleep in the babies' dormitory. Julia refused to go, and so she was locked up and a second endurance test was started. Every now and then Julia was asked to go upstairs, and after six hours Julia was ready. Miss Haviland won, but she won on an issue that was totally irrelevant to the first issue—namely, obstinacy about the explanation. She contends that afterward Julia gave her no more trouble. That may be, for Julia had probably learned her lesson with Miss Haviland; but would Julia never be obstinate with another person? Did she not get a training in the idea that she had to be conquered before she would be good? Miss Haviland won out in her determination to have Julia sleep with the babies, but Julia won out in her determination not to talk. The reader surmises that Julia never told her.

The author presents a most excellent idea on page 43: "Growth cannot be forced from without—it must be fostered from within;" but elsewhere in the book she seems to superimpose virtues and ideals on top of what may already exist. Miss Haviland's friend of page 84 has a shrinking from voicing her ideas publicly because she has never made the effort successfully. The author says, "If she would once summon her will to make the effort, the chances are that she would succeed." I do not believe her friend could summon her will to make the effort; if she could, it is likely that she would, without any prodding. I think her friend's real problem in life is not facing a listening public, but facing life; some other problem is distressing her.

Character is trained, the reader gains from this book, by a development of work, play, and religion. Although readers have been accustomed to hearing of a fourth agent—namely, love—Miss Haviland omits that altogether; not even does she encourage a toleration of a child's playmates, teachers, or parents.

She says, "Light work is very desirable both for the exercise it gives and because it occupies the mind and prevents the blues." Psychiatrists believe that play and work simply distract attention from the source of the blues, as well as from the blues themselves, and that they distract attention only temporarily and do not ever in themselves settle one's original problem. Light work and play are only procrastination as regards settling the blues.

The author says that the slum is the creator of the irreverent and lawless, and a reverent spirit cannot be built up in surroundings that are not beautiful. Does she forget that "the colonel's lady and Judy O'Grady are sisters under their skins?" Does she forget that the "tough guy" can be born in a mansion, wear good clothes, and have money in his pocket? Does she not forget that the idea of the beautiful is relative and that one born in the slums might consider, without educational interference, works of art to be uninteresting, but a cheap colored print to be beautiful? Does she know the line from *Sir Launfal,* "There's never a leaf or a blade too mean to be some happy creature's palace," and the line, "Be it ever so humble, there's no place like home"?

THADDEUS H. AMES.

New York City.

RELIGION AND THE NEW PSYCHOLOGY; A PSYCHOANALYTIC STUDY OF RELIGION. By Walter Samuel Swisher, B.D. Boston: Marshall Jones Company, 1920. 255 p.

Considered as a popular discussion of an important problem, this is an excellent little book. It is all that one can expect in a book written by a layman (neither physician nor ethnologist) on a subject that interests the general thinking public intensely and yet demands a knowledge technical and extensive for its accurate exposition. The author has gathered his material from a small range of psychoanalytic literature, which seems to have provided him not only with his clinical and psychopathological data, but also with his mythological and sociological lore. The psychoanalysts consulted have garnered their knowledge as to savage life and custom from Frazer and similar uncritical compilers of secondhand reports. In consequence of these repeated selections of evidence, the finished product is, inevitably, dogmatic rather than critical. It would be unfair, however, to condemn the work on this account. The problem is so broad and so technical that it will probably be years before it is discussed in a scholarly way. In the meantime certain broad principles should be published in which intelligent people are interested and, on the whole, these principles are truthfully and fearlessly set forth by this clergyman.

In his introduction he points out that a sharp distinction must be drawn between mental mechanisms and mental content and that, therefore, there can be nothing disruptive of true religious faith in a discussion of the way man thinks religiously. The form in which man casts his belief in unseen powers, or the neurotic or insane use he may make of his creed, has nothing whatever to do with the question of the existence or nonexistence of God. In other words, it is only the spurious in religion that can suffer from psychological analysis. It might have been better had he repeated this statement at various points throughout the book, to obviate the danger of shocking the devout follower of some modern sect, who is apt to need restimulation of his logical faculty during the discussion of such a topic as this.

The argument of the book may be briefly digested.

Primitive religion is not ethical, for the savage is a creature of appetites. Good and bad fortune are the work of the "gods," and "sin" is simply an activity that may arouse the capricious wrath of a jealous god. Religious myths are sexual in origin (for instance, the widespread Adam and Eve story) and the ubiquitousness of sex accounts for the universal appearance of similar primitive religious beliefs. "Conviction of sin" is an echo of inner conflict, and this conflict does not appear till, in the process of evolution and civilization, organized society appears. This society forces a conflict between the needs of the individual and the needs of the group. One type of cravings has to go, and the personal instincts are repressed. Thus is born the "unconscious," which contains primitive impulses. In modern man dreams reproduce the primitive sex myths, providing an outlet for this repressed material. All religions begin with phallic worship and tend to keep the phallic symbol in the foreground of their ritual.

He next gives a fair presentation of the conventional Freudian hypotheses of repression, the unconscious, the universal sex content, and so on. Then the argument proceeds: religion is primarily emotional; emotions arise in the unconscious; therefore, religion is of necessity much influenced by unconscious forces. He explains certain features of Christianity on this basis. The Jews were a people suffering from national repression on the part of the Romans. To them a belief in deliverance, in a new world, was a natural development. To these people Christ preached a religion of sane expression and love. Immediately on His death, however, disciples, particularly Paul, who were demonstrably neurotic, grafted onto this simple teaching various inhibitions, which were accepted as essential to Christianity. At the same time the persecuted Jews seized on the new religion as a vehicle of expression for their national ambitions. Hence came the future-life elaborations of Christianity and its ascetic, emasculating restrictions.

Then he goes on to a discussion of motives from the usual psychoanalytic standpoint, and this leads to consideration of the age-old problem of free will versus determinism. Consciously we may not seem to have free will, but this is because we are dominated by the unconscious. But choice has been exercised in the division of ideas between the conscious and the unconscious minds. Hence, by including the latter category, we are seen to have more free will than at first sight appears. [So far as it goes, this argument seems specious.] He then applies the hypothesis of the unconscious to other religious questions. Mysticism is demonstrated to be an expression of repressed sexuality to which it gives an outlet. Then there is the problem of evil. This may be looked on as external or cosmic for one type, and for another as internal or human. It is the latter which he analyzes. The idea of original sin comes from the unconscious, which is vaguely recognized as an evil force. Another evil is seen in morbid fears. These may be caused by forcing ethical standards on a child not developed sufficiently for their assimilation; by threats of punishment for infractions of this artificial code; by poor sex education, with its inevitable sequels; by bad advice from physicians ignorant of psychopathology. These are objective, remediable influences which work to produce a sense of inborn wickedness. If such "evils" were prevented from developing, there would be much less talk of the "evil" that has bulked so large in the discussion of theology.

His next division has to do with bizarre religious movements or practices. First there is the unconscious sadistic tendency which accounts for religious persecution and the persistent repression of innocent pleasure for pleasure's sake. Its counterpart is the unconscious masochism which backs the ambition to be a martyr. A good statement is made about religious insanity in general. It is not religion *per se* that drives a patient insane, but religion used pathologically as an outlet for abnormal tendencies. Important religious movements have to do with occultism. As to this he says that one does not need to discuss at this point whether there is such a thing as survival after death or not. The important thing to recognize is that the unconscious seems to be the medium through which alleged evidence of survival is produced and that it has frequently been proved that the unconscious manufactured the evidence. The attraction occultism has for many people is in its representing a flight from reality. Sudden conversion is another phenomenon to be studied. It is potentially present in the unconscious fantasy of rebirth. A clinical parallel is found in recovery during psychoanalytic treatment, when the conflict is transferred to the physician, just as the convert is content to leave it all to God and gains an analogous mental relief. [This view of the mechanism of cure in psychoanalysis is established more by repeated statement than by logical argument. The peace of mind engendered by successful psychoanalysis and that resulting from conversion are largely the same symptomatically, but the psychological mechanisms that produce one or the other are too intricate to be disproved of in this summary manner.]

The failure of the modern churches is due, Swisher thinks, to a clinging to the old beliefs in "sin," vicarious sacrifice, the need for repression, and so on. All of these are neurotic or primitive beliefs which modern culture has outgrown. An attempt has been made to combine religion with medicine in the various forms of faith healing, some of which are based on superstition and some on a conscious effort to utilize the teachings of psychopathology. In all cases the conditions remedied are essentially neuroses of the hysterical order, and the mechanism of recovery is that of suggestion. The author is evidently sympathetic towards such a program as that of the Emanuel Movement, where religion may be combined with an honest effort to use the scientific methods of modern psychotherapy.

Finally he speaks of religious problems in education. There may be reëducation of adults by psychoanalysis, or psychoanalytic insight may aid greatly in the education of children. All psychoanalytic truths are capable of use in religious training. The Bible should not be made a fetish, but its true meaning and history understood. Moral truths should be implanted only on a properly developed and prepared soil. He also suggests that biblical stories and precepts may be used as a basis for sex education.

Two appendices present evidence as to dream mechanisms and birth dreams.

If Swisher's authorities are drawn from a narrow group, his conception of religion is equally narrow. Throughout, his idea is that of an intensely individual faith elaborated to meet individual needs. As a matter of fact, the most primitive religions open for inspection to-day show more of group than individual psychology in their make-up. The rôle of herd instinct as a basis for religious feeling in general, as a component in all individual conflicts, as a factor in mystical and occult experience—all this is omitted. The author speaks as a preacher rather than a student, for his tone is everywhere dogmatic. For instance, he says, " . . . it is true that all our psychic life is in the broadest sense based on sex. . . ." Freud has never gone so far as that. Similarly he states that all religion is phallic in origin. He is, of course, unaware that an important school of ethnologists claims that phallic symbolism occurs only in the path of megolithic culture.

The scientific faith of the author seems to be that there is but one Freud and that Coriat is his prophet. This sums up the deficiencies of the book. If one were to discard it for this reason, a grave mistake would be made. It is not written for scholars. A really critical dissertation might bore those who can derive great profit from a perusal of Swisher's work. The problem of reconciling religion and modern psychopathology is urgent for many people. They can learn here how it *may* be done. And if the reconciliation be performed exegetically rather than analytically, that is the method ninety-nine people out of a hundred prefer and get most out of. So we wish it success in its proper field.

J. T. MacCurdy.

New York City.

THE PROBLEM OF NERVOUS BREAKDOWN. By Edwin Ash, M.D. New York: The Macmillan Company, 1920. 119 p.

In reviewing Dr. Ash's book, one is impressed with the fact that the author draws his material from a long and varied experience with the nervously ill and indisposed and that this work is an attempt to lay faithfully before the reader in a simple and popular style the results of his experience, without recourse to fads or pet systems to make it interesting.

He discusses in detail the superficial and palpable causes of nervous breakdowns, and his descriptions of the various types of nervous disorders show an intimate acquaintance with their symptomatology. He devotes a chapter each to *The Neurasthenic Condition, Morbid Fears and Doubts,* and *Nervous Indigestion.* To hysteria and multiple personality he devotes three chapters. On treatment he deals justly and fairly with drugs, electricity, massage, and suggestion. To "the rest cure" he devotes three chapters. Diet and recreation likewise receive attention. In the above respects Dr. Ash's book does not differ, except in so far as it is conservative, from the many popular works that have appeared in recent years.

What one does find lacking in this work, in common with so many similar books on this problem, is a lack of understanding of the problem from a biological viewpoint. After all, it is not domestic and financial difficulties with their attendant worries, or grief and shock at the death of relatives or dear friends, that bring about nervous breakdowns, but it is some underlying lack of or defect in biological adjustment that makes it possible for these worries or shock to precipitate a nervous breakdown. Neither is it the rest cure, diet, or recreation that cures the patient, but a better adaptation to the underlying cause, or the latter's removal, in many cases without the patient's being aware of it, or by the patient's gaining a clear insight into the real difficulties and knowingly correcting and surmounting them.

Education and enlightenment in assisting the patient to "know himself" are rather more important than the rest cure. Enumeration of symptoms and reiterations that worry, etc. are causes of nervous breakdowns are hardly justified in any work at the present time unless the mechanisms that operate to bring about mental ill health are simply and plainly set forth. In this respect Dr. Ash has failed to state, elucidate, and give helpful advice on the problem of the nervous breakdown.

M. W. RAYNOR.

Manhattan State Hospital.

STUDIES ON INBREEDING. By Helen Dean King, Ph.D. Philadelphia: Wistar Institute of Anatomy and Biology, 1919. 175 p.

The publication is a reprint of a series of four papers that appeared originally in the May, July, October, 1918, and August, 1919, issues of the *Journal of Experimental Zoology*. The first of these papers presented the results of Dr. King's work as bearing on "the effect of inbreeding on the growth and variability in the body weight of the albino rat;" the second, the effect on "fertility and constitutional vigor;" the third on "the sex ratio;" and the fourth paper supplemented the first by a discussion of additional data from later generations. Considering the fourth paper as simply a continuation of the first, the investigations cover a series of twenty-five generations of continuous brother-sister matings, the closest possible inbreeding in mammals. Altogether the material consisted of 3,408 litters and 25,452 individuals. The work undoubtedly constitutes the most extensive as well as the most critically guarded experiment on the inbreeding of mammals that has yet been accomplished.

The first six generations of the experiment appeared to confirm the general belief, as well as the results of previous investigators, that inbreeding is distinctly deleterious in its effect. This result was discovered to be due to malnutrition and was not the result of the inbreeding *per se*. When the diet was corrected, these effects were eliminated. What, therefore, was technically an error in the setting up of the experiment proved to be a variation that threw much light on the results. By careful selection of the breeding animals, not only was degeneration avoided, but in the characters considered there was marked improvement. In body weight the later generations showed definite increase with decreased variability. As to fertility and constitutional vigor, the balance was also in favor of the inbreds.

The problem of the sex ratio is, of course, an entirely different question. Two strains of the inbred stock were maintained—strain A, selected for excess of males, and strain B, for excess of females. These strains were shown to remain distinct as to maleness or femaleness generation after generation, so that this character in the rat appears to be "amenable to selection." Inbreeding as a whole, however, tends to an excess of females. Discussion of these results leads to many questions which Dr. King has sought to answer by a special series of experiments since reported elsewhere.

The investigation gives increased weight to the present tendency of biological workers to regard the effects of inbreeding as essentially a genetical more than a physiological phenomenon. Dr. King's work is an important contribution to science as furnishing a more definite understanding of the nature and effects of inbreeding, and while it emphasizes the error of the older conception that inbreeding is inherently and indiscriminately evil, it also raises the very significant question whether indiscriminate inbreeding, such as usually characterizes cousin marriages in the human species, is not likely to prove in general more pregnant of evil than out-marriages in the same population. In other words, her work suggests that inbreeding is a highly specialized and critical form of breeding, and hence can be safely carried on only under the most rigid of control conditions. This means that the prevailing belief and popular prejudice as to the practical evil of inbreeding is well founded. The ordinary farmer and commercial poultry raiser, if he be not an expert breeder, will find it more practicable to maintain the quality of his stock if he avoid the pitfalls of too close inbreeding.

HOWARD J. BANKER.

Eugenics Record Office, Cold Spring Harbor, N. Y.

A STUDY OF WOMEN DELINQUENTS IN NEW YORK STATE. By Mabel Ruth Fernald, Mary Holmes Stevens Hayes, and Almena Dawley, with statistical chapter by Beardsley Ruml and preface by Katharine Bement Davis. New York: The Century Company, 1920. 542 p.

The purpose of this comprehensive study was to attain a more adequate understanding of women delinquents. The groups of women studied include 102 at Bedford Reformatory, 88 at Auburn State Prison, 76 at the New York Magdalen Home, 110 at the New York County Penitentiary, 109 at the New York City Workhouse, and 102 probation cases from the women's night court of Manhattan and the Bronx, making a total of 587 cases. Each group was thoroughly studied, and careful comparisons were made of the findings. The results were also compared with those found by other investigators in both delinquent and general population groups. The principal topics treated in these comparisons are nature and extent of delinquency; age; habits with respect to use of tobacco, alcohol, and drugs; general social factors; nativity and color in relation to delinquency; early home conditions and family status; educational background, occupational history, and economic efficiency; sex irregularities and mental capacity.

In one of the most valuable chapters in the book mental capacity is correlated with other factors that might influence delinquency. The authors find that the average mental capacity of women delinquents is somewhat lower than that of the average of women in the general population. They do not, however, agree with Goring that constitutional factors are of greater importance than environmental factors as determinants of crime. The fact is emphasized that delinquency in women cannot be traced to any one predominant factor, but results from a large variety of interrelated causes.

The study seems to indicate that native-born colored women have the highest rate of delinquency, native-born white women a considerably lower rate, and foreign-born white women a still lower rate.

The study as a whole is a valuable contribution to our knowledge of women delinquents, and great credit is due the authors for their thorough investigation of individual cases. One could feel surer of the statistical conclusions if the number of cases studied were larger. The statistical tables and drafts are admirably presented, and the limitations of each are clearly set forth. The frequent use of standard deviations and ratios of correlations with the accompanying discussions of the probability of error makes some of the text too technical for the average reader. This painstaking statistical work, however, increases the value of the book to the student of social science.

HORATIO M. POLLOCK.

New York State Hospital Commission.

THE SECRET SPRINGS. By Harvey O'Higgins. New York and London: Harper and Brothers, 1920. 243 p.

Of late various lay writers have been running a race with the professionals to see which can convey the best understanding of psychoanalysis and yet make a book on this subject entertaining. *The Secret Springs* undoubtedly caps the sheaves of them all, for the author, an able, capable litterateur, essays to turn an amusing handspring over psychoanalysis. But the result is very unsatisfactory; it is not good reading because of the monotony of one case wonder being quite like another, nor is the exposition of any one case clearly set forth. The book depicts the chief ringmaster of psychoanalysis as a mere mountebank; he is like Colonel Sellers, or the doctor in *The Stark Monroe Letters.* There is no doubt that the book is of a light and entertaining texture, but the weave is too flimsy. Had the author not been in an all-to-evident vaudeville haste, a half dozen of any of his numerous incidents could have been made of vital dramatic moment. The work then would not have been overcrowded, and a more lasting effect would have been made upon the reader's mind. *The Secret Springs* are too shallow and brackish to refresh or greatly entertain, and certainly will not assuage a real thirst for psychologic knowledge. Compare this book with the brilliant writings of the author in other fields, where he shows a real mastery of style and motive, and see how great is his present sin.

L. PIERCE CLARK.

New York City.

MAN'S UNCONSCIOUS PASSION. By Wilfrid Lay, Ph.D. New York: Dodd, Mead, and Company, 1920. 246 p.

The author has presented in as non-technical a manner as possible the workings of the conscious and unconscious mind and its relations to passion and affection. In each chapter of the book he treats of some phase of the reaction of man's inner life of love in a developmental way. The first chapter deals with a glimpse of the unconscious life, with an interpretation of its influence upon the whole life and its reaction to pleasure-pain stimuli. One is then prepared to discuss the mechanism of unconscious and conscious passion. The author emphasizes the infantility of society in thrusting sexuality into a state of repression, since it thus becomes, according to the author, a cause of prostitution, of divorce, and of most of the disharmonies from which society now suffers.

Woman, by being compelled to repress her sexuality, manifests her emotional activities in the wrong place. Man's emotional activities also become manifest in the wrong environment. This repression which society calls forth, plus the infantile fixations through the parent-imago, forces one to retain the attachment of the past and hence prevents adjustment being made properly toward the reality of the present. The relation of the mother to the child and later the unconscious directing of the child, manifested in the Œdipus-complex or an incestuous complex producing "an aged soul in a young body," are factors Lay uses in approaching the subject of prostitution. He thus indicts the mother as responsible for man's selection of a prostitute. This carrying over of the fixation he has directed toward the perfection or imperfection of marriage. He says, "Only the man with the liberated unconscious passion is really free to achieve a union with a woman well developed physically and mentally." It is this unliberated unconscious passion that is the cause of much bitterness, gross misunderstanding, and long unhappiness.

This book will undoubtedly be accepted by the general reader. It, too, will arouse interest in the various social problems of the day. There may be a danger, however, in popularizing this subject and thus introducing into the minds of the laiety misconceptions directly related to those problems with which society has to deal. Instead of being an aid, it may ultimately become a barrier.

FREDERIC J. FARNELL.

Rhode Island Society for Mental Hygiene.

THE HUMAN FACTOR IN EDUCATION. By James Phinney Munroe. New York: The Macmillan Company, 1920. 317 p.

The Human Factor in Education cuts a wide swath. It ranges from such chapter topics as *The Real Superman, The Political Animal,* and *Child Idleness* to *College Trustees and College Faculties* and *Employing the Handicapped.* It attempts a humane interpretation of educational purposes. It is a stimulating and refreshing book filled with good sense. If the author's educational doctrine could penetrate the minds of the American teachers who need it most, and convert them to humane educational practices, countless children would call him blessed. Education is a great social business. The task of the schools is to prepare young life for future social well-being. Education, however, can be only partly given by the schools. The author's remedy for the present pedagogical uncertainty is characteristic of the book: "It is not to make the schools church schools, it is not to read more chapters of the Bible, it is not to teach formal ethics and to repeat maxims; it is to educate the teachers in such a manner and to such a degree that they shall understand what education really means; it is to give each teacher so small a number of pupils that she can establish between herself and each of them a path of understanding and of sympathy, and can send all her instruction straight along that path to the inner chambers where character is building. The essence of the remedy, however, is to emphasize and reëmphasize the fact that the home is the center and mainspring of all education, and that the father and the mother, who are the responsible heads of that home, must learn and must practice their profession as the chief and finally accountable educators of the coming citizens."

ERNEST R. GROVES.

Boston University.

STUDIES IN INDUSTRIAL PSYCHOLOGY. By E. A. Bott. No. 1: *A Point of View.* No. 2: *Juvenile Employment in Relation to Public Schools and Industries in Toronto.* (University of Toronto Studies. Psychological Series. Vol. IV.) Toronto: The University Library, 1920. 125 p.

Under the first of these two titles, Professor Bott has given a clear and concise account of the significance for the social sciences of certain phases of contemporary psychology. Special emphasis is placed on the work in individual differences and in the rôle of instinctive responses. Finally a special problem is proposed which appears to offer a field for the application of these studies—namely, the failure of the schools to prepare adequately for industrial life those children who leave school at an early age to seek employment.

The second paper of the volume reports an investigation of juvenile employment in Toronto pursued under the auspices of the Canadian National Committee for Mental Hygiene. Its findings include the following:

Neither homes nor schools in Toronto are furnishing adequate training in the moral attitudes pertinent to industry, as, for example, regularity, responsibility, and interest in proficiency and in service.

Of the children who leave school for work, 23 per cent are under fourteen, the legal age; 46.5 per cent more leave between fourteen and fourteen and one-half. Sixty-two and six-tenths per cent leave, not from economic necessity, but because in their judgment it is best to do so. Sixty-four per cent show a weakened interest in school before leaving, by diminished regularity in attendance.

Wages earned during the first year of employment show little relation to amount or quality of previous school work. This tends to increase among these children and their families the underestimation of the value of school work for an industrial career.

In the selection of first positions, children are guided largely by interest in temporary wages or by trivial grounds of preference, relatively little by any adequate consideration of their own capacities or of permanent opportunities for advancement. Similar motives of minor importance lead to frequent changes of position.

School teaching should provide increased proficiency in fundamental subjects such as arithmetic and writing, and should lay increased emphasis on important character traits such as punctuality, regularity, attentiveness, and responsibility.

Methods of promotion should be planned in a way to diminish discontent and the consequent desire to leave school.

In raising the age limit for compulsory attendance, it is important to persuade the portion of the population most affected of the advantage of the change.

Since a large proportion of the children who leave school for work take positions either immediately or within a short time as factory operatives, educational and placement policy should be adapted to this fact.

As much as possible of the knowledge that teachers and school physicians acquire about children in school should be embodied in a continuous school record. This should be supplemented by group intelligence tests, and, for special cases, by individual intelligence tests and consultations of principals with school physicians.

An organization for coöperation between parents, teachers, and employers should be established. A vocational counselor should be appointed to have active charge of vocational guidance.

A plan should be instituted whereby employers would in the initial positions give preference to children with good school records. By personal persuasion and vocational talks in school, the importance of school training should be emphasized.

Coöperative plans for further investigation and experimentation should be perfected.

DAVID CAMP ROGERS.

Smith College.

THE PSYCHOLOGY OF CHILDHOOD. By Naomi Norsworthy and Mary T. Whitley. The Macmillan Company, 1920. 375 p.

This is a book designed for teachers and normal-school students, but the reviewer has found it distinctly valuable to a college class in child psychology and principles of mental hygiene. For a descriptive study of children as differentiated from adults, it is unequaled. The physiological basis of tendencies and Thorndike's classification of instincts is adhered to throughout, although the general point of view can easily be termed eclectic. One of the most agreeable features is the signally well proportioned treatment, there being no overweight upon any one aspect of the child's mental phenomena. Accordingly the dynamics to all tendencies to action are not assigned to the sex instinct, but recognition of the tremendous rôle of the latter is not confined to the single chapter so designated.

The so-called normal stages of physical and psychical sex development from earliest childhood receive careful consideration, departures therefrom not being handled in detail. Yet an attempt is made to indicate the etiology of these phenomena and suggest means of prevention and wise handling of exceptional children. Very sane opinion follows on the training of the sex activity, the time, sources, and kind of instruction that seem most effective with different individuals, and the duty of the teacher in reference to this most intricate problem.

A further satisfying feature of the book is the clarity with which it points out many fallacious popular opinions, prevalent misconceptions, and suppositions now quite contradicted by experimental evidence, such as the belief that children can memorize better than adults, that they instinctively imitate every form of behavior they see, that they instinctively fear certain animals, water, or the dark, that prenatal culture influences a child in the direction of music or what not.

The chapters devoted to the analysis of play interests, habit formation, and moral and religious tendencies are broadly conceived and profitably constructive for the young student.

MIRIAM C. GOULD.

Vassar College.

CHILDREN'S DREAMS. By C. W. Kimmins, M.A., D.Sc. London: Longmans, Green, and Company, 1920. 126 p.

This author collected nearly six thousand dreams of children from five to eighteen years of age. Children of seven years of age and under gave a verbal account of their dreams, while children of eight years of age and over were told: "Write a true and full account of the last dream you can remember. State your age, and also say about how long ago you had the dream you have described."

While some mention is made of psychoanalysis in the introductory chapter, no attempt seems to have been made to analyze any of these dreams from a psychoanalytic standpoint; merely a classification of them was made as some element was objectively observed of "the various types of wish fulfilment and fear dreams; kinaesthetic dreams; references to fairy stories; dreams of bravery and adventure; school activities, cinemas, exciting books and death incidents; dreams in which conversations are recorded; the presence of other witnesses than the dreamer; and dreams in which the dreamer was absent," as well as the influence of the general environment upon the dream, the influence of wealth, poverty, the war, blindness, deafness, the state of intelligence of the subject, etc. Evidently the author has gone through his large collection of dreams with each of these elements or influences in mind, noting the per cent at different ages in which they occur, but without inducing the patient to enlarge upon his first account and without attempting a psychoanalytic analysis in any individual case. He draws his deductions from group study. He quotes many interesting dreams which show potential neurotic elements, although he presumes that nearly all of his subjects are free from neuroses.

His book, then, will be of interest only in part to one well informed in abnormal psychology, and cannot be very instructive to one not well informed. He advances the view that careful study of the dreams of normal children will be of great advantage in determining the best trends of ability, in effecting better education and efficiency, and in preventing neurotic or psychotic tendencies from developing further.

GLENN E. MYERS.

Los Angeles, California.

THE PASSING OF THE COUNTY JAIL. By Stewart Alfred Queen, Ph.D. Menasha: George Banta Publishing Company, 1920. 156 p.

This study consists of a consideration of the methods of dealing with misdemeanants commonly known as the county-jail system. The report is an outgrowth of work done by the author while secretary of the California State Board of Charities and Corrections. It presents material discussed under the following headings: (a) The county-jail system; (b) Substitutes for the county-jail system; (c) Inmates of county jails, and other misdemeanants; (d) Misdemeanants and felons, an outgrowth classification; (e) A basis for individualization; (f) A unified correctional system.

The introduction purports to discuss what the author considers the way in which modern retributive justice has developed. "The offender stands from the beginning in the rôle of an enemy, or at least a source of danger to the group." "The reformer has emerged through seeing in the offender more than an enemy, and more than a piece of property." "Perhaps it was the delinquency and punishment of a kinsman or a friend that occasioned this situation, perhaps it was a personal experience," etc. The chapter on the county-jail system presents rather concisely and concretely very damning evidence of the shortsightedness and viciousness of some of our methods of handling misdemeanants. The tremendous variation in the policies of peace officers with reference to itinerant laborers and tramps, the wide range in the percentage of convictions, the great variety of sentences imposed by judges on the same men for the same offenses, etc., lead the author to suspect that the treatment of misdemeanants is determined by the disposition of the judge, his theory of punishment, or the capacity of the jail, but not by a settled policy based on knowledge of the real needs of these men.

The author calls attention to the short sentences given to jail inmates, and says, "Remembering that many have firmly fixed habits of idleness, or at the best of intermittent work, and excessive use of liquor or drugs, or other vices, the significance of these short sentences must impress itself upon us. Such habits are not broken in ten days or in thirty; much less are they replaced by industry and sobriety."

The rest of the chapter is taken up with the discussion of the physical condition of the jails, prison discipline, and the fee system, as well as the "floater" custom, in regard to which he states: "It seems apparent that no county is willing to assume the burden of caring for all petty offenders, real or alleged, who happen inside its borders. Probably no county ought to undertake this task, but somebody should, and logically that body is the state." The author mentions a certain town—Marysville, California—where one day in 1915 a large number of men, perhaps two hundred, were driven out by the officers. All in all, a very dark picture of the county-jail system is painted, but fortunately something better is already in the making.

In the chapter on substitutes for the county-jail system, the author discusses the *"outdoor work"* plan, the *"workhouse"* or *"house of* *correction,*" the "*local farm colony,*" probably the best example of which is the District of Columbia workhouse at Occoquan, Virginia, and the "*state farm for misdemeanants*" as developed in Massachusetts, Rhode Island, Indiana, and New York. He mentions also the specialization that has lately developed in dealing with limited groups, such as vagrants, inebriates, and prostitutes, and the efforts in Switzerland and Belgium to deal with vagrants and beggars in so-called "forced-labor colonies" and "free-labor colonies."

Finally, a most important substitute for the county-jail system is to be found in the ordinary court procedure in connection with probation and parole. The author devotes too little attention to this, probably the most important of all the various substitutes he has discussed. The remarkable progress now made by probation in the states of Massachusetts and New York he entirely overlooks. Both of these states, having official state probation commissions and large field forces of probation officers, supplying nearly every court in the states, are doing much toward changing our old methods of handling misdemeanants in jails.

The chapter on *The Inmates of County Jails and Other Misdemeanants* is the weakest part of the book. The effort of the author here is to prove that there is no misdemeanant type; he seems to have taken too seriously a statement made by some one that delinquency and mental defectiveness are synonymous terms. He publishes certain tables intended originally by the authors of the articles from which they were extracted to call attention purely to the different types of mental condition found in a clinic in the courts, and without any reference to the frequency with which these types were found amongst offenders in courts, he uses these tables as evidence of the great frequency of abnormal types among offenders, according to certain extremists—evidence in which he himself places little confidence.

He emphasizes "that there is a wide range of mental ratings among misdemeanants, and that there is nothing here by which to differentiate them from the rest of the population." His whole handling of this phase of the question is most inadequate and shows a lack of sound knowledge of psychiatric studies of jail inmates. He concludes this chapter with the following statement: "Native ability, intelligence, and education, all seem to average less than in the non-criminal population. But the misdemeanants include all grades of mentality, from imbeciles to superior individuals, from illiterates to college graduates." This all may be very true, but it is the least important consideration in connection with the mental condition of jail inmates. The great frequency of mental disease and deterioration, epilepsy and psychopathic personality, as well as feeblemindedness, are matters of far more importance in the way of a practical program for treating these offenders than purely the question of intellectual rating. His statements regarding the physical condition of inmates of jails also deserves to be challenged. He states that physical defects are no more frequent than among non-delinquents. It is unfortunate that the author, if he intended handling this matter at all, should not have gone over the literature on the subject of the physical condition of offenders in penal and correctional institutions.

A very strong case is made out for doing away entirely with the old and possibly outgrown classification of misdemeanants and felons. This chapter is well written and presents the evidence most convincingly.

The last chapter of the book summarizes the studies made and makes a plea for a unified correctional system. The following important propositions are made:

1. "The county-jail system is unutterably bad, but it seems to be giving away in two directions—individualization and centralization."
2. "Individual misdemeanants present so many different traits and so many different problems that no set of fixed penalties can meet their various needs. The things worth emphasizing are their individual differences and their common humanity."
3. "In no important way can misdemeanants be distinguished from felons as a group. Hence there seems to be no good reason for maintaining two distinct sets of institutions—state prisons and local jails."
4. "These facts seem to point the way very definitely toward individualization through a unified correctional system."

That sort of individualization which is both feasible and worth while is (1) "to study each offender in order to learn so far as possible in what sort of a group and under what circumstances he is likely to make successful adjustments;" (2) "to form groups of prisoners likely to develop together and to establish progressive conditions under which their development is likely to take place."

He discusses the New York plan for a clearing house at Sing Sing, and the distribution of the prisoners to the other state institutions, in the light of the findings in the case of each individual offender, and finally concludes with a model plan of a unified correctional system for California. The book contains a serious indictment of the county-jail system and helpful constructive suggestions for the better handling of misdemeanants. It is distinctly worth reading.

V. V. Anderson.

The National Committee for Mental Hygiene.

DIE GEISTESKRANKHEITEN DES KINDESALTERS EINSCHLESSLICH DES SCHWACHSSINNS UND DER PSYCHOPATHISCHEN KONSTITUTIONER. By Theodore Ziehen. Berlin: Reuther and Richard, 1917. 491 p.

This treatise must be regarded as a significant addition to psychiatric literature because there is a dearth of books dealing even slightly with the mental disorders of children. Ziehen observed one case of general paralysis as early as six years of age and dementia praecox at seven. He considers manic-depressive psychoses not infrequent in school children as well as hysterical psychasthenia and other psychoneurotic conditions. Epileptic deterioration is mentioned and a large group of psychopathic constitutions, including neurasthenic, obsessive, paranoid, hyperthymic, and others. In contrast to the prognosis of such conditions in adults, the author says children may recover from them or develop a defined psychosis or continue in a static phase.

He discusses four possible combinations: (1) simple psychopathic constitution, (2) feeblemindedness + psychopathic constitution, (3) psychopathic constitution + fully developed psychosis, (4) feeblemindedness + psychopathic constitution + fully developed psychosis. In terminology and classification he is not strongly influenced by Kraepelin, and his point of view, while not markedly progressive, is nevertheless interesting. The book deserves translation that it may come within the reach of more who would find it profitable.

MIRIAM C. GOULD.

Vassar College.

HARVEY HUMPHREY BAKER, UPBUILDER OF THE JUVENILE COURT. Boston: The Judge Baker Foundation, 1920. 133 p.

To those who are familiar with the part Judge Baker had in the development of juvenile courts, this book will be especially welcome. Mr. R. M. Cushman, on account of his long association with Judge Baker, is especially well fitted to write an account of Judge Baker himself, and his work.

Two contributions from the pen of Judge Baker are included in the book, one not previously published—an analysis of the statistics of the court for the first five years of its existence. It is doubly valuable because it gives both the facts and Judge Baker's interpretation.

The book closes with a modest statement of the work of the Judge Baker Foundation.

A. W. STEARNS.

The Massachusetts Society for Mental Hygiene.

Nerves and the Man. By W. Charles Loosmore, M.A., Brown Scholar at Glasgow University. New York: George H. Doran Company, 1921. 219 p.

The author of this book says he knows what "nervous breakdown" really is from personal experience and the experiences of others whom he has met and dealt with. It is "a popular psychological and constructive study of nervous breakdown." There are twenty chapters, which contain, aside from its introduction, a brief description of the nervous system, the nature of "nervous breakdown," and what the author considers the causes and the remedies.

The book is written in a pleasing style. Many of the chapters contain at the end a list of valuable "Don'ts." The material is presented clearly and describes well the nervous individual, his mental uncertainty and lack of grasp, his vagueness of impressions, weakness of association, and difficulty in memory, his introspective, inverted type of personality. The author emphasizes the need for sympathy and understanding of these individuals and suggests as treatment the control of the emotions through a healthy and positive expression, relaxation through religion and play, mental control through the development of attention and the inhibitions. For those individuals with a marked feeling of inferiority and undue timidity, the chapter on *Poise and Serenity* should especially appeal. They are urged to look firmly and frankly into the eyes of another, to control the voice, to be frank, sincere, and calm, not to depreciate themselves too much, and above all to have "moderate expectations of life and a faith that life is ordered for our good." At the end of the book we read, "The mind is made for order and efficiency and peace. But it cannot put itself in order. We ourselves must do that, and though religion and a straight life can do much to further this great end, we ourselves must take the initiative, working along common-sense and psychological lines." This, in a way, summarizes the author's view.

One readily perceives that the matter contained in the book concerns what we generally understand as neurasthenia, with its many symptomatic ramifications. Whether this material covers "nerves and the man" is very questionable. If one interprets "nervous breakdown" as neurasthenia, the book should prove helpful to individuals affected with this condition; at least it can do no harm, if we exclude physical factors proper and the Freudian possibilities. Faith, hope, religion, laughter, and so on will not effect underlying physical disease. The treatise leaves little for the medical man to do.

Ralph P. Truitt.

Illinois Society for Mental Hygiene.

AMERICAN POLICE SYSTEMS. By Raymond B. Fosdick. New York: The Century Company, 1920. 408 p.

As a companion volume to his earlier publication, *European Police Systems*, the author has now brought out *American Police Systems*, which he has written after a careful personal study of the police systems in some seventy cities in the United States. The opening chapter deals with the American police problem as compared with that of Europe, greatly to the disparagement of the former. There are, however, certain reasons for this, among which are the heterogeneity of the population as compared with the homogeneous groups of Europe; the preponderance of crime in America "due to a certain degree to the make-up of our population, quite apart from the inefficiency of our police forces;" the failure on the part of attorneys and courts to back up the police, who, after all, are but a cog in the machinery of justice; the tendency of the courts to delay; uninforceable laws, "laws in America being what the people will back up;" and, lastly, the attitude of the public, for, says Mr. Fosdick, "the weak sentimentality of the community in relation to crime and the criminal is a final factor in the failure of our administration of justice which cannot be overlooked. Offenders go unpunished and the laws are used as a shield for crime because such laxity is after all in substantial accord with public opinion. Crime is an offense not only against the individual, but against the whole structure of society. Until public opinion adjusts its own point of view on these matters, we cannot expect the courts to reflect anything better. . . . The task before us is far greater than the regeneration of our police. It is the regeneration of our whole system of administering justice and the creation of a sound public attitude toward crime."

The development of our police system from the days of the "parish constable" and "night watch" up to the present day is described, and in a clear-cut manner the author shows the various police systems as they are, bringing out in each case the reasons why each system developed as it did, pointing out its flaws, and suggesting ways in which improvement might be made.

"All police work has as its goal the *prevention* of crime. It is a matter for surprise, therefore, to learn that even were we to secure 100 per cent efficiency in our patrol and detective work, most crimes would still go unhindered. . . . The average police department is still too much merely an agency of *law enforcement*, divorced from responsibility for the *causes* of crime. Its energies are consumed in defensive measures, in efforts to correct the manifestations of crime rather than attack its roots. . . . Just as yellow fever was successfully attacked by draining the swamps and morasses where it bred, so the attack on crime is, in part at least, a matter of eliminating the breeding places. Crime develops from contact and bad environment."

"The bulk of crime, certainly of crime against property, is committed by those who have previously been in the hands of the police. . . . Too often the attitude of society and the police has made any other career than crime impossible for an ex-convict. The handicap of his previous record, his inability to secure employment, and the constant 'hounding' by the police, make it difficult for him to rehabilitate himself and easy to continue in a life of crime."

The closing paragraph puts the matter plainly: "We have, indeed, little to be proud of. It cannot be denied that our achievement in respect to policing is sordid and unworthy. Contrasted with other countries in this regard, we stand ashamed. With all allowances for the peculiar conditions which make our task so difficult, we have made a poor job of it. Our progress has fallen far behind our needs. Successful in the organization of business and commerce, preëminent in many lines of activity, we must confess failure in the elemental responsibility laid on all peoples who call themselves civilized of preserving order in their communities. Surely in the new era upon which we are entering, with its challenge to forms of government and political faiths, the vision of America will not be blind to the grave importance of the problem and the resourcefulness of America will not be baffled in attempting the solution."

The author is especially qualified for such an undertaking, and his study gives one the impression of a very fair, unbiased picture of our police systems as they are, taking into account the difficulties encountered, unhesitatingly pointing out the serious defects of which we may well be ashamed, but giving credit where credit is due and always endeavoring to supply constructive suggestions on points where destructive criticism has been imperative. The book should awaken every American citizen who reads it—and it is to be hoped that many of them will—to a realization of existing conditions and a desire and determination to create a better system.

J. J. JOSLYN.

New York School of Social Work.

HOW TO DEVELOP YOUR WILL POWER. By Clare Tree Major. New York: Edward J. Clode, 1920. 186 p.

This little book is not a "complete course in the development of will power" as is stated on the cover, but it is a useful and pleasing publication. It is seasoned with sound, everyday philosophy and in the majority of instances the psychology approaches the present-day teachings. The author considers the individual from the physical, emotional, and intellectual viewpoints, and while she demonstrates that the three are closely related, she attempts to show and succeeds in showing the importance of each. The book teaches the necessity of exercising emotional control, making emotion serve the individual instead of the individual's serving it.

This work is better than most of its kind. We cannot concur with the author in some of her statements, but the fault lies in the fact that inspirational books must speak with "authority" and it is frequently difficult to make definite statements in regard to psychological theories.

The author has not presented us with any new thought, but she has presented her ideas in an agreeable manner. Her book will be of value if placed in the hands of the border-line inadequates.

William B. Terhune.

Connecticut Society for Mental Hygiene.

The Fundamental Principles of Learning and Study. By A. S. Edwards. Baltimore: Warwick and York, 1920. 239 p.

This is an unusually good selection from orthodox psychology of information valuable to parent and teacher. Education is interpreted as a process of habit formation, the success of which is measured by the permanent results it produces in the life of the individual. The form of the book is influenced by the fact that the material was first presented as lectures to college students.

The book follows the traditional normal-school type of psychology. The discussion makes no use of the knowledge of the deeper aspects of habit revealed by psychoanalysis. For example, the twofold nature of the habit problem is ignored. And yet one of the most illuminattng facts regarding habit formation is the possibility, disclosed by analytic psychology, of building up in the individual a habit of external conduct and at the same time an inner hostility, perhaps unconscious, toward the habitual behavior, a hostility expressed in an increasing, deep-seated protest.

Regarding the function of the schools, the book contains easy-going assumptions, which, however well they may express the thought of the professional educator, are fortunately not as yet established sociological doctrine or the decision of public policy. An instance of this is the author's statement "that the endeavor of educators to-day is to direct the activities of children for a larger number of hours out of every twenty-four." (p. 196.) This program of extending school control and necessarily narrowing family responsibility will find vigorous opponents in those who think it better to assist the home to perform its proper functions, and who are sceptical regarding the superior social efficiency of the schools. Their reluctance to turn more of the child's life over to the schools is due to their sympathy with Trigant Burrow's statement[1] "that the perfunctoriness and sterility of the educational systems of the day, with their deficient opportunity of outlet for the inspirational interest of the child, are the external factors which are responsible for the regressive permutations of consciousness represented in neurotic affections, whether they are presented under the negative aspect of the neuroses or in the exaggerations and distortions of the sexual instinct presented in the out-spoken perversions or in so-called normal life."

ERNEST R. GROVES.

Boston University.

PSYCHOLOGY FOR TEACHERS. By Daniel Wolford La Rue. New York: The American Book Company, 1920. 309 p.

Psychology for Teachers, as its title indicates, purposes to crowd into a niche already overfull. It presents the material that we have learned always to expect in such books. It has the customary class exercises and innumerable topics for further study. Here and there are evidences of contact with recent psychological discoveries, but for the most part it keeps to the well-beaten path. The book is well put together and deserves a place with its kind. Only the discriminating teacher, however, will get from it assistance for the practical processes of teaching.

ERNEST R. GROVES.

Boston University.

YOU CAN, BUT WILL YOU? By Orison Swett Marden. New York: Thomas Y. Crowell and Company, 1920. 338 p.

SUCCESS FUNDAMENTALS. By Orison Swett Marden. New York: Thomas Y. Crowell Company, 1920. 307 p.

These are two of thirty-eight so-called inspirational books produced by this author. The first of the two has a religious trend. One chapter is devoted to the description of a new philosophy of life, which turns out to be, after all, only a brief statement of New Thought theosophy. While many of the assertions in the book are generally accepted as true, most of the attempted scientific explanations are erroneous.

The message of the second is that health, efficient utilization of potential energy, self-analysis, and confidence are the fundamentals of success. However, these ideas are not clearly expressed, or rather, are masked by trite phrases that have little relationship to the subject under discussion. While this book is not scientifically accurate or philosophically sound, it contains many stimulating thoughts.

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[1] *Journal of Abnormal Psychology,* Vol. II, p. 185.

The book might be described as a shotgun prescription for success, and it is doubtful whether any of the ingredients are sufficiently active to produce the desired results. Success is, to a great extent, an individual concept, and its attainment is doubtless only relatively possible. If one's idea of success is to outshine neighbors, to amass money by any possible means, to cultivate selfishness, egotism, and self-deception, it is barely possible that this book might help one to realize one's desires.

WILLIAM B. TERHUNE.

Connecticut Society for Mental Hygiene.

NOTES AND COMMENTS

Alabama

Plans for the first unit of the Alabama home for mental defectives have been completed. This institution was authorized by the 1919 legislature.

California

A bill that was designed to make insanity a ground for divorce was defeated in the 1921 assembly.

District of Columbia

A bill recently introduced in Congress would establish in the Department of the Interior a bureau for the study of criminal, pauper, and defective classes. The work of this bureau would include laboratory investigations and the collection of sociological and pathological data, especially such as may be found in institutions for the above-mentioned classes. The bureau would be in charge of a director, who would have the assistance of an alienist and a psychologist.

A bill has been introduced before Congress to establish a school and home for mental defectives of the District of Columbia. This bill is identical with the one presented in 1919. The institution would be known as the Columbia Training School. It would be situated in Maryland or Virginia on a site of not over 1,500 acres. Its board of control would be composed of seven citizens of the District of Columbia, at least one of whom should be a physician with special experience in the diagnosis and treatment of mental diseases and mental deficiency.

The bill provides for the commitment by the Supreme Court of the District of Columbia of feebleminded persons of not less than six years of age, upon the petition of a relative, guardian, or any reputable citizen of the District. The hearing on the petition must be by the court and a commission, appointed by the court, consisting of two qualified physicians or one qualified physician and one qualified psychologist, and evidence shall be heard by the court without a jury. The commission must make a personal examination into the mental condition of the alleged feebleminded person, and evidence shall be heard and inquiry made into the social conditions.

This bill also provides for the admission of feebleminded and epileptics between the ages of six and twenty-one years without court procedure, upon the application of parents or legal guardians. The person making such application must provide for reimbursement for care and treatment. Any person thus admitted shall not be retained unless in the opinion of the superintendent such person is feebleminded or epileptic.

Florida

The state institution for mental defectives and epileptics, which was authorized by the 1919 legislature, will be ready to receive patients about the middle of September.

Illinois

A bill to establish a farm colony for male mental defectives with criminal propensities was introduced in the 1921 legislature of Illinois. An appropriation of $750,000 for this purpose was included in the bill.

A bill empowering school boards to establish special classes in the public schools for children who are subnormal, delinquent, mentally deficient, blind, deaf, dumb, or crippled, was introduced in the 1921 legislature. The state of Illinois would pay the excess cost of maintenance of these classes.

A bill authorizing the governor to appoint a state psychologist was presented before the 1921 legislature. The bill states that the state psychologist must have had "adequate training in general and applied psychology, the methods employed in the mental examination of children, and the educational methods employed in teaching and training exceptional and abnormal children." His duties are defined as follows: "(1) To advise and assist school officials of the public schools in the establishment of special classes for children who are subnormal, backward, mentally deficient, delinquent, blind, deaf or crippled; (2) To suggest courses of study, educational methods, and special educational care for the different groups of abnormal children; (3) To examine, with the assistance of medical experts, when necessary, children who are subnormal, backward, mentally deficient, delinquent, blind, deaf, or crippled and recommend their placement in special classes; this service to be performed upon the request of superintendents, principals, or other school officials of the public schools of any community in the state; (4) To make reports to the Superintendent of Public Instruction at such time and in such manner as the Superintendent of Public Instruction may request."

Iowa

A law recently enacted relative to admissions to the state institution for mental defectives removes all age restrictions.

Massachusetts

An important law enacted by the 1921 legislature provides for an investigation by the Department of Mental Diseases into the mental condition of certain persons held for trial. It reads as follows: "Whenever a person is indicted by a grand jury for a capital offense or whenever a person who is known to have been indicted for any other offense more than once or to have been previously convicted of a felony is indicted by a grand jury or bound over for trial in the superior court, the clerk of the court in which the indictment is returned, or the clerk of the district court or the trial justice, as the case may be, shall give notice to the Department of Mental Diseases, and the department shall cause such person to be examined with a view to determine his mental condition and the existence of any mental disease or defect which would affect his criminal responsibility."

Some of the advantages of this law are as follows: It will tend to stop the flow of recidivists to penal institutions. It recognizes the importance, both to the individual and to the state, of attempting to understand a chronic offender instead of blindly keeping him on the legal treadmill. It provides that examination shall take place before the state has gone to the expense of a trial.

Another law, which will become effective July 1, 1923, includes psychiatry as one of the subjects in which an examination must be taken by applicants for registration as physicians in this state.

Minnesota

A bill making insanity for a period of ten years a cause for divorce, which was introduced in the 1921 legislature, failed.

Missouri

The four state hospitals for mental diseases, the state sanatorium, and the colony for feebleminded and epileptic are hereafter to be under the management of one board. This board is to be appointed by the governor with the approval of the senate and is to be composed of six persons, not more than three of whom shall belong to the same political party. The president of the board must be a person of business and executive ability. He is to have charge of the business management, with direct supervision over the stewards of the several institutions.

The board of managers must appoint a health supervisor, not one of their number, who shall be well known and skilled in psychiatry. It is not necessary for him to be a resident of Missouri at the time of his appointment. He shall prescribe the qualifications that must be possessed by appointees to the position of superintendent of any institution coming under the supervision of the board. The superintendents of the hospitals for mental diseases and of the colony for feebleminded and epileptic must be skilled in the practice of medicine and in the treatment of mental diseases. The health supervisor has the authority to transfer employees or assistant physicians from one state institution to another. His duties are defined as follows: "The health supervisor shall maintain an office at the state capital, and it shall be his duty to supervise and direct in the manner of the treatment of the health and sanitation of the several institutions under his charge and management, and shall advise and counsel with the superintendents thereof and the several assistant physicians therein and he is authorized and it shall be his duty to see that proper scientific methods are applied in the treatment of the ailments of the inmates of the said several institutions and he may require the superintendent or any assistant physician to make such report or reports touching said institution or any patient therein as in his judgment he may deem necessary. He shall visit and carefully inspect each institution at least once every two months."

New Hampshire

Chapter 29, Laws of 1921, states that the board of trustees of the New Hampshire State Hospital shall constitute a commission in lunacy. This law became effective March 10, 1921. The title, powers, and duties of this commission were formerly vested in the state board of health.

New York

The bill to convert the reformatory at Napanoch into a state institution for male defective delinquents has been approved. This institution was transferred to the jurisdiction of the State Commission for Mental Defectives on June 1. Similar provision for women has been made at the Bedford Reformatory, by the creation of a special division for defective delinquents.

Chapter 673, Laws of 1921, permits the superintendent of any hospital for mental diseases, with the approval of the State Hospital Commission, to arrange with municipal or county officials or other persons to make the laboratory service of his hospital available to municipalities or counties nearby. This law also eliminates the necessity of personal service upon the patient, in case of court commitment, when such course is recommended by the examining physicians. It requires that the substituted service be made upon the next of kin other than the petitioner. Another provision requires the judge to state in writing his reasons when he refuses to issue an order of commitment.

The following provision for emergency admission is included in this law: "The superintendent or physician in charge of any hospital or institution for the care and treatment of the insane, except the Matteawan and Dannemora state hospitals, may receive and retain therein as a patient any person suitable for care and treatment, on a verified petition made by any person with whom the alleged insane person may reside, or at whose house he may be, or the father or mother, husband or wife, brother or sister, or the child or next of kin available, or an officer of any well-recognized charitable institution or home or any overseer of the poor of the town or superintendent of the poor of the county in which any such person may be, accompanied by a certificate of insanity executed by a physician possessing the qualifications set forth in section eight-one, on a form prescribed by the State Hospital Commission. A person thus received at such hospital or institution shall not be detained therein more than ten days if he, or any person in his behalf, shall make written request for release, unless the superintendent or physician in charge thereof shall deem such detention necessary, and shall so certify, with the approval of the State Hospital Commission, to a judge of a court of record, who may in his discretion, forthwith, issue an order committing such person to such institution for care, custody, and treatment."

North Carolina

Chapter 183, Laws of 1921, restores the management of the state hospitals for mental diseases and the state school for the feebleminded to separate boards of directors. Formerly the state hospitals had one general board. Each board is to be responsible for the management of its institution and make its report to the governor.

A law, enacted in 1919, that would transfer to the State Hospital at Raleigh the land and buildings of the state prison, was repealed by the 1921 legislature.

Oregon

The "hygienic marriage" law, enacted by the 1921 legislature and referred to the voters of the state, was defeated by about 5,000 votes at the general election in June. This law was summarized in the April 1921 number of MENTAL HYGIENE.

Washington

An administrative code was enacted by the 1921 legislature. This code divides the state government into the following departments: (1) the department of public works, (2) the department of business control, (3) the department of efficiency, (4) the department of taxation and examination, (5) the department of health, (6) the department of conservation and development, (7) the department of labor and industries, (8) the department of agriculture, (9) the department of licenses, and (10) the department of fisheries and game.

The duties of the former board of control are taken over partly by the department of business control, partly by the department of efficiency, and partly by the department of health. One of the duties of the director of business control is to appoint a state dietitian who shall make and furnish to the department food analyses showing the relative food value, in respect to cost, of food products, and advise the department as to the quantity, comparative cost, and food values of proper diets for the inmates of the state institutions under the control of the department.

The director of this department is also authorized to appoint a supervisor of farm management, a supervisor of industrial management, and a supervisor of buildings and grounds. These officers have the supervision of the farm management, the industries, and the building program at the state institutions. The supervision of the care and treatment of patients at the state hospitals for mental diseases and at the state school for mental defectives is vested in the department of health. The duties of the director of health are thus summarized in the code: "(1) To exercise all the powers and perform all the duties now vested in, and required to be performed by, the state commissioner of health; (2) To, with the assistance of the state registrar of vital statistics, exercise all the powers and perform all the duties, in relation to the registration of vital and mortuary statistics, now vested in, and required to be performed by, the state commissioner of health, the superintendent of registration, and the state registrar; (3) To, not less often than once each six months, visit and inspect each of the state institutions, ascertain the sanitary and health condition existing at each of said institutions, require the respective governing authorities thereof to take such action as will conserve the health of all persons connected therewith, and report his findings to the governor."

The director of health, with the head physicians of the women's industrial home, the school for the feebleminded, and the state hospitals, and one woman physician to be appointed by the governor, shall constitute a board to be known as the "Institutional Board of

Health." This board has the power to visit each of these state institutions and advise the superintendent regarding care and treatment, and, with the advice and assistance of the state dietitian, prescribe general rules to provide for a healthful diet for the various classes of patients. The superintendent, however, may or may not adopt the suggestions of the institutional board of health.

West Virginia

A state institution for the treatment and training of mental defectives has been authorized by the 1921 legislature. This institution is to be known as the West Virginia Training School. The law creating it stipulates that its superintendent must be "a legally qualified physician, scientifically trained in mental medicine and of not less than five years' experience in the treatment and care of insane persons and mental defectives." He is to be appointed by the governor with the advice and consent of the senate.

Applications for commitment of persons to this school are to be made to the county mental-hygiene commission, composed of the president of the county court, the prosecuting attorney, and the clerk of the county court. A relative or any reputable citizen may make application. The commission appoints two physicians to examine both physically and mentally the alleged mental defective. These physicians shall be selected as being the most capable ones available because of knowledge of and training in mental medicine. They must certify to the commission their findings, upon a form prescribed by the state board of control. A prisoner on trial who appears to the judge to be mentally defective may be committed to the West Virginia Training School in the same manner as a mental defective for whom application is made. Mental defectives in state institutions may be committed also to this institution upon the application of a relative, guardian, or friend.

The superintendent of this institution has the right to parole any patient who has improved to such extent as no longer to be a menace to himself or others, under rules prescribed by the board of control. The law states that "the training and treatment of persons admitted to the school shall be along such educational, medical, and industrial lines as have proved most effective in approved institutions for mental defectives. The medical staff of such institution, and the medical staff of Weston, Spencer, and Huntington state hospitals, are hereby authorized to administer such medical treatment and perform such surgical operations for the inmates therein as may be necessary and expedient for the cure and prevention of mental defectiveness or disease."

NATIONAL CONFERENCE OF SOCIAL WORK

At the last meeting of the National Conference of Social Work, which was held in Milwaukee June 22-29, it was voted that the Mental Hygiene Division of the conference be made a permanent one. This action indicates that social workers recognize the social aspects of the problems in the field of mental hygiene, although these problems are primarily those of conserving individual health and of effecting necessary adjustments between individuals and their environments.

The meetings of the Mental Hygiene Division, under the chairmanship of Dr. Thomas W. Salmon, were devoted chiefly to the mental hygiene of childhood. Special emphasis was laid upon conserving the mental health of the normal child and also on the need of understanding the emotional factors in his personality. The program of the division was presented in full in the April number of MENTAL HYGIENE.

Mr. George A. Hastings of New York was elected chairman for the coming year and Dr. Smiley Blanton of Madison, Wisconsin, vice-chairman.

ANNUAL MEETING OF THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION

An interesting session of the annual meeting of the American Medico-Psychological Association, held in Boston, May 31 to June 3, was devoted to the discussion of community service of hospitals. The clinical papers at this meeting were largely upon the subject of dementia praecox. The association voted to change its name from the American Medico-Psychological Association to the American Psychiatric Association. The name of the official journal was likewise changed from the *American Journal of Insanity* to the *American Journal of Psychiatry*. Dr. Albert M. Barrett, Director of the State Psychopathic Hospital, Ann Arbor, Michigan, was elected president; Dr. H. W. Mitchell, Superintendent of the State Hospital at Warren, Pennsylvania, vice-president; and Dr. C. Floyd Haviland, Superintendent of the Connecticut State Hospital, secretary. The 1922 meeting will be held in Quebec or Detroit.

ASSOCIATION FOR THE STUDY OF THE FEEBLEMINDED

The Forty-fifth Annual Session of the American Association for the Study of the Feebleminded was held in Boston, May 28-31. The education and training of mental defectives and the care of mental defectives outside the institution were the subjects that received most attention in the papers. The program included also visits of inspection to the Waverley State School and the Wrentham State School. The following officers were elected: President, Dr. Joseph H. Ladd, Superintendent of the Exeter School, Slocum, R. I.; Vice-president, Dr. C. B. McNairy, Superintendent of the Caswell Training School, Kinston, N. C.; Secretary and Treasurer, Dr. Benjamin Ward Baker, Superintendent of the New Hampshire School for Feebleminded, Laconia, N. H.

California Society for Mental Hygiene

Dr. Harold W. Wright, of San Francisco, California, has been elected president of the California Society for Mental Hygiene.

The American Psychopathological Association

A program of unusual interest was presented at the annual meeting of the American Psychopathological Association, which was held at Atlantic City on June 11. The morning session was devoted to a symposium on The Relative Rôles in Psychopathology of the Ego, Herd, and Sex Instincts. Dr. Bernard Glueck, New York City, spoke on *The Ego Group;* Dr. Sanger Brown, II, New York City, on *The Herd Group;* Dr. C. Macfie Campbell, Boston, on *The Sex Group;* and Dr. John T. MacCurdy, New York City, gave a general summing up of the subject. Discussion was opened by Professor William McDougall, Boston. The papers at the afternoon session were *Le Mécanisme Psychologique de la Peur de l'Action,* by Dr. Pierre Janet, Paris; *Experimental Study of Hallucinations,* by Dr. Morton Prince, Boston; *Medical Policies as to Sex Advice,* by Dr. Adolf Meyer, Baltimore; *Sex and Hunger,* by Dr. Isador H. Coriat, Boston; and *Epileptoid or Fainting Attacks in Hypopituitism,* by Dr. L. Pierce Clark, New York City.

Scholarships in Occupation Therapy

The School of Practical Arts, Teachers' College, Columbia University, in its prospectus of courses in occupation therapy for the year 1921-22, announces that two scholarships in this subject have been offered by Montefiore Hospital. The amount of a scholarship will cover the expense of instruction at the college. Applicants should communicate with the Director of Occupations at Montefiore Hospital, Gun Hill Road, New York City. Information as to courses, living expenses, etc., can be obtained from the Secretary of Teachers' College, Columbia University.

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MENTAL HYGIENE

VOL. V OCTOBER, 1921 No. 4

THE SIGNIFICANCE OF THE CONDITIONED REFLEX IN MENTAL HYGIENE

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THE main facts in regard to the investigations of the conditioned reflex are now familiar to psychologists and psychiatrists, or in any case literature in regard to them is easily accessible (7).[1] The history of these studies need not be recounted; but the significance of the results for mental hygiene is not yet generally understood. The purpose of this paper is merely to suggest that many important educational and hygienic subjects are most clearly understood and perhaps most profitably investigated from the point of view and by the method of the conditioned reflex.

The importance of the scientific method is fortunately recognized in mental hygiene as well as in somatic hygiene; and as regards the method of the conditioned reflex, the great advantage of it lies in the fact that with this method one's feet are on the solid ground of scientific fact while unusual and mysterious problems are studied. Even if at present one's results are meager, the student has at least the advantage, to his own personal mental health and to the healthful development of scientific hygiene, that comes from the use of scientific methods in any subject; and the results have a well established value because they can be verified by any competent investigator who can repeat the conditions. The question may well be raised whether one of the first important things is not to determine how far the problems of mental hygiene may be explained by a few of the very simple fundamental principles of scientific psychology.

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[1] The number in parenthesis refers to the bibliography at the end of this article.

Theoretically, two great epochs in the development of the brain and mind can be distinguished. First, the development of the new brain, the neencephalon, or the brain cortex and its appendages; second, in the mental field, the development of associative memory. I say theoretically two epochs, because no dramatic beginnings of either the brain cortex on the one hand or associative memory on the other can be distinguished. But each appears in a gradual evolution. First in the selachians, the lizards, serpents, and the like, appear the beginnings of the new brain; and since that time in the animal series gradual development of the neencephalon has proceeded until we have the marvelous complexity of millions of interrelated neurones in the human brain cortex. The function of the central nervous system, we may say roughly, is to make protoplasmic connection between the receptor and the effector organs and to convert stimuli into reactions.

The significance of the new brain lies in the fact that its function is that of association; and the animal with this new brain has the ability to profit by its own experience, and what we speak of as the marvelous learning ability of the human being. For our present purpose, it is merely necessary to recall these fundamental facts, especially this ability to form associations.

ASSOCIATION AND THE STUDIES OF PAVLOV

The laws of the association of ideas have long been known; but only recently was it discovered that when stimuli of disparate character—for example, sensations of taste and sound—occur simultaneously, they, too, become associated and the laws of this association are in large part similar to the laws of association of ideas. This was a great discovery. The method[1] based on this fact promises scientific results in many baffling problems.

The discovery of the association of stimuli was made by Russian investigators, the chief of whom is Pavlov (32, 33, 34). This great physiologist has studied the secretion of the salivary gland in the dog as affected by different stimuli, and developed a most elaborate technique for this purpose; but the results may be described in very simple language. We may take the classic example, a story often told, but still as wonderful as ever.

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[1] For the technique see the literature, especially numbers 1, 2, 3, 25, 27, 29, 38, 40.

If you give your dog a piece of meat, a secretion of saliva occurs. The stimulus of the taste or odor of the meat is followed by the secretion of saliva as a response. This is an ordinary spinal-cord reflex. If, every time you give your dog a piece of meat, you ring a bell, after a while you can ring the bell without giving the meat and nevertheless there will be a flow of saliva. The sound of the bell has become associated with the stimulus of the meat and produces the same physiological reaction of the gland. Such an associated stimulus is called a conditioned, or associated, stimulus, and the reaction produced a conditioned reflex. In this case, according to Pavlov, the association is functioned by the brain cortex.

According to Pavlov, to note first his general view, the function of the higher brain centers is governed by the fundamental principle of the flow of nervous energy toward the point of greatest irritability; and as a matter of fact, this point shifts from one part of the cortex to another, and consciousness is, we may assume, the correlative of this shifting affectability. Pavlov, to be sure, puts this as a monist and makes consciousness itself a physiological phenomenon; but the general theory holds as well, and is quite as scientific, if we study this shifting focus of irritability as the mere correlative of consciousness, leaving the question of the relation between consciousness and the neural processes as a metaphysical problem with which we are not concerned. Thus Pavlov's picturesque metaphor may be adopted as translated by Morgulis (30):

"If it were possible to look through the skull, and if the region of optimum affectability in the hemispheres were lighted up, we might see in the thinking, conscious human being a bright spot of fantastically ragged outline, of perpetually changing form and size, migrating over the hemispheres, surrounded by more or less complete darkness hanging over the rest of the hemispheres."

In other words, this focus of irritability in the cortex, constantly shifting from one part to another, we may naturally suppose is correlated with one's consciousness or one's special activity; and the other and relatively inactive parts are the correlative of what is commonly called the unconscious and our possible activity. That is, they are potentially related to consciousness; and when the focus of optimum irritability shifts to them, they in turn become correlated with conscious activity. Besides all this, however, we must suppose there is a process of shifting irritability and the fusion of stimuli not correlated with consciousness, but nevertheless forming the association of stimuli in conditioned reflexes.

We may, then, to put the whole matter with arbitrary simplicity, say that the brain cortex seems to be the seat of a constant ebb and flow of excitability. To use the word focus or center loosely, as Pavlov and Krasnogorski (24) do, we may say that certain centers are continuously the seat of greater or less irritability, and whenever stimuli from the different receptor organs come in to the cortex, they tend to associate themselves with those centers which are especially stimulated at the time. Or, in other words, the path of least resistance is the path which is already the seat of excitation or in the direction of such an excited center. Hence the great fact of association—that any stimulus, however indifferent, tends to become associated with other stimuli which at the given moment are active in the brain cortex.

A simple illustration used by Hough may make this condition clearer. We may liken the paths of increased irritability between nerve centers that are excited, or between new stimuli that come into the brain cortex and the centers that are in a condition of highest irritability, to the areas of increased intensity of illumination in different parts of a room lighted by electric lights. In the paths between the different lights there is a greater intensity of illumination than in other parts of the room. If we imagine a room lighted by such electric lights which are constantly shifting their position, we have the analogue of the shifting irritability in the brain cortex between different centers that are in a condition of excitation, and between stimuli that occur simultaneously.

Physiologically, the great significance of the conditioned reflex is that it furnishes an objective method of studying the function of the cortex; psychologically, it is of importance as a method of studying association.

Pavlov's students have produced a large amount of data, the investigations having been made with dogs, monkeys, and children. A vast number of illustrations could be cited. If you sound a definite tone every time you give the dog meat, then that tone becomes associated with the original stimulus and produces the flow of saliva without the meat. Whistling is capable of association to produce the same conditioned reflex. Scratch the dog in a definite place every time he is fed, and a conditioned reflex is formed for the scratching. Even pain on a definite spot of the skin may become associated to produce a similar conditioned reflex. If we may trust these investigators, even place a piece of ice on the skin every time the dog is fed and, after a number of repetitions, you may merely place the ice on the skin and the flow of saliva will occur.

Now when a piece of meat is the stimulus that makes the dog's mouth water, it does not especially excite our wonder because we are familiar with such simple reactions; but when an entirely indifferent stimulus—a musical note, or the ringing of a bell, a piece of ice on the skin, or even a painful sensation, an electric shock, or the like—becomes associated with the meat and produces the same reaction of the gland, it certainly is remarkable; and possibly for every gland in the body and for every motor organ, similarly associated stimuli can produce specific reactions.

Of course the stimuli that occur naturally in an animal's environment have the same effect as those artificially supplied in the laboratory. This is why, in experiments on the conditioned reflex, it is necessary to take such great precautions —to use a special room, sound proof, the experimenter himself, in some cases, being in another room and operating the apparatus without being seen by the subject of the experiment, in this way isolating the special stimuli one is studying.

It has been found by Pavlov and his students that, either under the controlled conditions of the laboratory or under the ordinary conditions of natural environment, any stimulus whatever, from any receptor organ, however indifferent the sensation, may become associated with the biologically adequate stimulus and produce the same effect—that is, produce a conditioned reflex.

The significance of all this is that Krasnogorski (23) in Russia, Dr. Mateer (27) at Clark University, and Dr. Watson (37) of Johns Hopkins, have found that in children as well as in animals similar conditioned reflexes can be formed, conditioned reflexes for the salivary gland, conditioned reflexes also for motor organs, conditioned reflexes, perhaps, for every gland and motor organ in the body.

INHIBITION

Pavlov's experiments have thus made clear what the conditioned reflex is—namely, a reflex produced by any indifferent stimulus associated with a biologically adequate stimulus. In other words, if an indifferent stimulus is repeated a certain number of times simultaneously with the biologically adequate stimulus, an association is formed so that it comes to pass that the associated indifferent stimulus produces precisely the same physiological effect. If we could leave the whole matter here, it would be relatively simple; but the processes in nature are seldom simple; and in this particular case, we have yet to consider the other side of the whole matter—namely, the function of inhibition.

If one scratches a dog every time he is fed, then the scratching becomes a conditioned stimulus; that is, it occasions a secretion of saliva when no food is given. Now when a conditioned reflex of this kind has been formed, if, during the scratching, a new stimulus—say, for example, a tone that has been made a special stimulus—is added, immediately the scratching stimulus loses its effect. Also, the adding of another unusual tone to a usual one inhibits the salivary reflex, the stronger the tone, the greater the inhibition. Pavlov and his students have made extended investigations of the different forms of inhibition, and they find that such a simple reflex as the secretion of saliva is influenced by innumerable factors, not only by the more intense stimuli, but by any stimulus from the environment, by any sound, however weak, the flickering of a light, a shadow on a window, or even a draft of air or the like.

Since the term inhibition has often been used vaguely and loosely, it is well here again to approach the subject from the objective point of view. Following Sherrington (35), we may sum up briefly the significant points. The first is the fact of the existence of inhibitory nerves and the inhibitory effect on the muscles of inhibitory summons from the nerve centers.

In 1846 Weber discovered the inhibitory action of the vagus nerve on the heart muscle. Later Pflüger discovered the inhibitory nerve that passes to the muscle of the wall of the intestine. Later other inhibitory nerves were discovered in invertebrates, but no such nerves to skeletal muscles in man could be discovered. These inhibitory nerves were efferent nerves from the nerve centers; but, as Sherrington has pointed out, it is not necessary to have such nerves directly to the muscle in the case of skeletal muscles in vertebrates. The muscle contracts only on behest of the motor nerve center.

This trustworthy scientist has shown that inhibition is a positive function, and he draws a significant parallel between stimulation on the one hand and inhibition on the other, in part as follows: Although the processes of excitation and of inhibition are polar opposites, and although one is able to neutralize the other, there are correspondences between reflex inhibition and reflex excitation. Both undergo fatigue. Both outlive their stimulation periods for a short time in proportion to their intensity. The latent period of both is about the same. Many of the time relations of the one resemble those of the other.

That the stimuli of the environment have power to excite this or that form of activity has long been known. That, on the other hand, these stimuli have power to arrest or inhibit such activity has been worked out only recently. The intimate nature of the reflex inhibitory process remains obscure; but, as Sherrington has described it, started by nervous excitation, reflex inhibition seems, detail by detail, to present an exact counterpart to nervous excitation. "Often the two processes meet and neutralize each other according to dosage, in appearance as do acidity and alkalinity."

"In all these uses of inhibition we see it as an associate of, and a counterpart or counterpoise to, excitation. Whether we study it in the more primitive nervous reactions which simply interconnect antagonistic muscles, or in the latest acquired reactions of the highly integrated organism, inhibition does not stand alone, but runs always alongside of excitation. In the simple correlation uniting antagonistic muscle-pairs, inhibition of antagonist accompanies excitation of protagonist. In higher integrations, where, for instance, a visual signal comes by training to be associated to salivary flow, the key of the acquiring of the reflex and of its maintenance is attention. And that part of attention which psychologists term negative, the counterpart and constant accompaniment to positive attention, seems as surely a sign of nervous inhibition as is the relaxation of an antagonist muscle, the concomitant of the contraction of the protagonist. In the latter case the coördination concerns but a small part of the mechanism of the individual and is spinal and unconscious. In the former case it deals with practically the whole organism, is cortical and conscious. In all cases inhibition is an integrative element in the consolidation of the animal mechanism to a unity. It and excitation together compose a chord in the harmony of the healthy working of the organism." (35, p. 309.)

In the field of the conditioned reflexes several forms of inhibition appear. Associated stimuli, on account of their unstable character, are especially liable to inhibition. Any new stimulus is likely to inhibit whatever conditioned stimulus is active; and then again any new stimulus is likely to inhibit the inhibition. Thus the whole matter of association, both in our coördinated activity and in our thinking, is extremely complex. Just as, in the case of the muscles, constant interplay of stimuli and of inhibitions occurs, so in the mental field we must conceive an equally complex interplay of associations and inhibitions, and a continuous action and reaction of stimulation and inhibition, in the conditioned reflexes and systems of conditioned reflexes that are active in any individual who has had experience—in the child after the first year and a half or two years, perhaps, of life, and in much more complex fashion in later years.

The inhibitory effect of the environmental stimuli referred to above is gradually to wear out the conditioned stimuli and the conditioned reflexes. Hence, as all the investigations show, the conditioned stimulus needs to be continually reenforced by association with the unconditioned or original stimulus; and when such repetition does not occur, the conditioned reflex soon disappears. This dying out of the conditioned reflex is thus to be looked upon as a form of inhibition, and concrete illustrations are plentiful.

Thus, while the first form of inhibition is the definite and sudden extinction of a conditioned reflex by inhibition of the associative stimulus by some new stimulus of sufficient intensity, the second form of inhibition is the gradual wearing out of the conditioned reflex by the inhibitory effect of the ordinary stimuli of the environment.

It should be noted that this condition of inhibition in turn is very unstable and easily removed by the occurrence of other stimuli. If, when a conditioned reflex has died out for lack of reënforcement of the associated stimulus with the original stimulus, some new stimulus suddenly occurs—for example, the light of an electric light thrown into the dog's eyes, a stimulus that has no relation to the original stimulus—it acts at once as an inhibition of the inhibition; that is, the sudden flash of the electric light removes the inhibiting stimulus and reëstablishes the conditioned reflex. One or two illustrations given by Anrep (1) may be cited:

"After repeated experiments with Dog 4, when the differentiation of the second sound had been firmly established [so that no secretion was expected], something irritated the mucous membrane of the animal's nose and the dog sneezed. Three minutes later an inactive note was sounded, and, instead of the zero anticipated, 28 drops of saliva were registered. No secretion was caused by the sneezing, but the irritation produced inhibited the inhibition."

"In another case, when experimenting with Dog 4, a large fly flew into the room; this very slight noise was quite sufficient to inhibit the inhibition and to cause the secretion of 15 drops. If a metronome or a simple bell is set in action during the sound of the inactive tone, one gets a still greater effect."

Thus the Russian investigators have shown the significance of inhibition for the nerves as Sherrington has for the muscles—i.e., that in all development and training of the central nervous system, inhibition is as important as response. According to Krasnogorski, stimulation and inhibition are in a certain sense the two halves of one and the same activity of the nervous system. And he maintains that in the conditioned reflex we have an almost ideal method of investigating the process of central inhibition in children.

We may simplify the complexity of the whole matter by a general statement such as that given by Anrep (1):

"Each extra stimulus in turn inhibits the conditioned activity of the brain, superimposing itself on the process it encounters in every part of the same. If it meets with excitation, it inhibits the excitatory process; if it meets with inhibition, it inhibits the inhibition."

I have referred to the discovery by Pavlov as remarkable, but, like many other great discoveries, it was in one sense very simple. For thousands of years nature has been forming conditioned reflexes and inhibitions. Any observer of children and animals can give examples.

In case of one of our Worcester dogs who is fond of visitors, the ringing of the doorbell has become associated with the coming of callers, so that whenever the dog hears the bell ring, he comes tearing into the house. The housemaid has discovered that when it is necessary to lock the dog up, the ringing of the bell is a convenient method for bringing him into the house. The presence of callers was the original stimulus, coming into the house the response. The ringing of the doorbell is the associated stimulus. It produces the same response—coming into the house—as a conditioned reflex.

A conditioned reflex is often established by shock or by a single intense association between the original stimulus and the associated stimulus. This can frequently be observed in the ordinary behavior of animals. Watson cites the well known case of the horse frightened in a definite spot and afterwards always showing fear when passing that particular place.

From the training of animals we have noteworthy examples also of the power of inhibitory stimuli. Kallisher has given so-called tone training to different animals. With monkeys, by giving them food with a certain definite tone and withholding it with other tones, he habituated them to grasping the food only at the proper tone, the one associated with the giving and eating of the food. In another case, a Boston terrier was taught to sit in his chair with meat placed before him until permission was given to take the food. Even when the dog's favorite food was placed directly under his nose and he was left in the room alone, he would not touch the food until his master returned and permission was given. In their natural environment also scores of inhibitions in animals are developed.

A great part of the training of animals consists in the development of conditioned reflexes, especially, perhaps, in the acquisition of the more unusual tricks. A friend of mine trained his dog to sneeze at the word of command, first rubbing his nose and causing the unconditioned reflex of sneezing in response to this irritation, then repeating the word of command with the rubbing until finally the dog would sneeze at command without the mechanical irritation. If in this case the sneeze was a true reflex, then we have a conditioned reflex, the word of command being of course the associated stimulus. More commonly the training consists largely in the development of inhibitions. The reader can add illustrations from personal observation.

We are specially concerned with the development of conditioned reflexes in children. The significance of inhibition in children will be considered later in connection with the school. Here it may be added that several kinds of inhibition are distinguished. Morgulis (30, p. 372) enumerates some of these as follows:

"There are several kinds of internal inhibition. Waning conditioned reflexes, due to a repeated application of the conditioned salivary stimulus without the aid of an unconditioned stimulus, is one kind. Another kind is the delayed reflex which appears if the conditioned stimuli are regularly followed by feeding a few seconds or even minutes after the conditioned stimulation has ceased. Conditioned inhibition is likewise a form of internal inhibition arising when an irrelevant factor is added to the conditioned stimulus, the combination not being reinforced by feeding. In such a combination the conditioned stimulus is quite ineffective, but alone it exerts the usual influence. The process of differentiation and concentration, already described above, represents a still other type of internal inhibition—the inhibition of differentiation. Furthermore, it is a very common and very important occurrence that an inhibition checks another inhibition, the result being a reactivation of the inhibited reflex."

LEARNING, FATIGUE, GROWTH

From the results already obtained, it is apparent that perhaps the most deep-seated significance of stimulation and inhibition in the production of conditioned reflexes lies in their relation to learning, fatigue, and mental growth. Learning in the broad sense—i.e., adjustment to a new situation—means the association of stimuli and inhibitions in the production of a system of conditioned reflexes. It means the inhibition or breaking down of reflexes that do not prove useful. It means remembering and forgetting as well.

What is called brain fatigue, even though its chemical cause be the toxic products produced by functioning neurones, is perhaps usually due, as Krasnogorski thinks, to some general inhibition—i.e., an inhibition so strong that it spreads over the whole cortex. To remove the fatigue, all that is necessary is a stimulus sufficiently strong to remove the cortical inhibition. The physical mechanism by which the removal of the inhibition is effected may be complex, involving the autonomic nervous system, the secretion of endocrine glands, and the like, but from our present point of view the essential factor in the process is the associated stimulus that inhibits the inhibition.

Again, what is sometimes called the plasticity of the nervous tissue—the ability to form, to retain, and to break down temporary associations—conditions mental development. Without this plasticity, we have that arrest of development we call feeblemindedness if it occurs before the age of fifteen or sixteen, dementia praecox, senescence, or the like, if it occurs after that age.

The different stages of decline in mental age, the arrests that occur in senescence, have not been systematically studied. But when an individual can no longer form and break down conditioned reflexes and habits (systems of conditioned reflexes), he is senescent, whether his chronological age be twenty-five or seventy-five. And one who can still form the temporary associations and adjust to the new situation is still young though his chronological age be ninety. The mental age, not the chronological age, is significant in senescence as well as in adolescence. The great aim of mental hygiene is to preserve this plasticity of the nervous substance.

The problem how this plasticity may be retained I am not able to solve. Its discussion would involve the study of other factors, such as the mental attitude and especially the proper functioning of the endocrine glands and the autonomic nervous system. The significance of the mental attitude to mental health is suggested by everyday observation as well as by laboratory studies of the higher mental processes. The normal functioning of the autonomic nervous system has been shown to be vital and fundamental to healthful mental development. But all this is another story that cannot be told here. The writer's task is the far simpler one of suggesting some of the practical applications of a knowledge of the conditioned reflex in education and mental hygiene.

The Conditioned Reflex in the Child

The power to form conditioned reflexes occurs at a very early age in the child. According to Krasnogorski (23, 24), this power of association appears in the first year of life, and observation and the studies by Dr. Mateer (27) indicate that it appears at a still earlier age. Probably in regard to a few things it appears in infancy; and yet, as Krasnogorski maintains, it is not developed until during the second year, perhaps not until the child is about two years of age.

The mechanism of conditioned inhibition also, according to Krasnogorski, occurs at the end of the first year of life, and this, according to him, marks the stage when the child can be really educated. Naturally there are individual differences in the time of development, and in the case of feebleminded children the conditioned inhibition can be formed only with great difficulty or not at all, and such associations have weak inhibitory effect and are easily destroyed. In normal children, however, in the first year or two of life, a vast number of conditioned reflexes and conditioned inhibitions are formed by the ordinary environment and by the training given by parents and nurse.

Obviously in the case of children the different learning types appear in the development of conditioned reflexes and there are rather wide individual variations in the ability to form associations. The results given by Dr. Mateer (27) are perhaps representative:

"It may be interesting to note that no child over two years of age needed more than eight trials, while none under that age used less than seven, none under three years needed less than six, while the minimum number, three, was all that were required by a child in the fourth year. Out of the fifty children, regardless of age, ten needed only three trials, eleven needed four trials, eleven used five trials, while only seven needed six; five needed seven, four needed eight, and two, nine trials."

The mechanism of the conditioned reflexes in the child varies from that of the animal in several respects. The first characteristic in the child is the extreme rapidity of its acquisition. In the case of the normal child, it is enough to let the effect of any stimulus occur in connection with the opening of the mouth from two to ten times for the temporary association to be formed and for the associated stimulus to call forth independently the opening of the mouth. Further characteristics of the conditioned reflex in the child are the high stability of the association formed and the ease with which it is broken down. The newly formed conditioned reflex in case of a normal child lasts for a long time, but at any time it can be quickly broken up and again reëstablished.

For the extremely interesting results of Krasnogorski's experiments on memory reflexes, and the mechanism of storage and discharge in children, and the technical methods used by Dr. Mateer, Watson, and Lashley in this country, reference must be made to the literature (26, 7). We are concerned merely with the simplest outline of the results of the study of the conditioned reflex and some of the wider relations and applications suggested.

In the case of a child, all the conditioned reflexes of the various kinds produced in animals may be produced and many others besides, apparently. The whole of the child's education from the early years is largely the development of conditioned reflexes from the stimuli of the environment. These are the reflexes especially significant for health.

The infant is conditioned to react to certain specific stimuli, certain sounds of the voice of the mother or the nurse indicating the time for nursing, the sight of certain places indicating the time for a nap, the sight of the bathroom and toilet indicating the time for the bath or the like, and later the sight of cup or spoon or the like indicating the opportunity for food or drink; and again the child is conditioned to certain forms of behavior by the petting or indications of favor and esteem of mother or nurse or playmates, and so on in a hundred ways. Still later, by the training of social groups, the child is conditioned to all the rules of the game—habits of politeness, the conventions of society, etc. Naturally the earliest and most important group of conditioned reflexes is developed in connection with the person and behavior of mother or nurse. As Kempf (22, p. 76) has expressed it:

"The mother's voice, facial expression, color of hair, odors, eyes, skin, the shape of her mouth and conformations of teeth, her neck, bosom, arms and hands, touch and step, postural tensions, irritability and goodness, habits, ideals, and eccentricities, are all stimuli that come to have a potent autonomic-affective influence upon the child through being *frequently, simultaneously* associated with the giving of nourishment, physical comfort, and relief from fatigue, loneliness, and anxiety. This continues as an almost incessant combination of stimuli, varying somewhat as the mother's affections (love, anger, sorrow, shame, pride, jealousy) determine her reactions to the infant."

Thus conditioned reflexes are formed in children at a very early age, and by the time they come to school they are bundles of such reflexes. These reflexes are formed in the most commonplace and unsuspected situations, in an ordinary environment as well as in the laboratory. Usually the association is produced by many repetitions. It may be produced by shock. A simple concrete case will serve as illustration.

While a young child was lying in bed, a curtain at one of the windows snapped up suddenly with a loud noise, and the child began to cry. The child was quieted, but the next time he was put in this room, he at once looked up at the window where the curtain was and again began to cry. The father was a physician and removed the child from the room. Had he not done so, a permanent conditioned reflex would very likely have been developed, so that the sight of the curtain would every time have made the child cry as a result of the conditioned reflex set up by the original shock, and his parents would have wondered why in the world the child was afraid of a curtain.

Simple incidents like this are especially instructive because they show that a conditioned reflex may be developed by a single experience, that what is a shock to the child may be the most commonplace and familiar experience to an adult. In this case the cause of the crying was obvious. In a hundred cases it may be unknown. Many of the cases of fear due to shock in early life are probably cases of this kind, and of course special care should be taken to avoid the formation of such reflexes.

THE SCHOOL

The school, of course, especially those schools in which the emphasis is placed on training rather than instruction, makes a systematic attempt to develop conditioned reflexes helpful for the tasks of life. The child, however, when he comes to school, is, as already suggested, a bundle of conditioned reflexes, some healthful and some unfortunate if not pathological, due to training in the home. Watson considers this training so vitally significant that he says: "I believe I could make or break a youngster in the first four years of its life; that is, without abusing it, starving it, or otherwise being cruel to it, I could twist, thwart, over- or under-develop its instinctive and emotional life to such a degree that it would never recover from it."

According to Watson's view, most of a child's behavior is acquired by training in the early years, and the instinctive and emotional mechanism is relatively simple. This of course means that the child's behavior is largely determined by conditioned reflexes. If this be true, then the tendency of stimuli to inhibit such reflexes and the various forms of inhibition of conditioned stimuli and conditioned reflexes, which Pavlov's studies have shown in such abundance, must be a significant factor in the child's life. Even by the time the child enters school, he is, from a physiological point of view, far from being unsophisticated; and, as regards health, even at this early age he may be handicapped by a large number of unfortunate inhibitions.

Formal education is largely made up of inhibitions. Necessarily this is so. The child's social education is chiefly a matter of acquiring inhibitions. The first thing in the social education of a child is to teach him to talk. The second is to teach him not to talk. The first scholastic education is to teach a child to read and to read every word and every sentence of his lesson; the later training of the scholar consists largely in teaching one what he should not read, and training one to ignore the unessential. To inhibit or delay reaction is the mark of the educated man.

Thus it comes to pass that sometimes repression goes too far, and an abnormal and exaggerated habit of repression is developed. This may be distinctly injurious to a person's character, and probably in not a few cases the most serious handicap to one's efficiency is such a habit of repression or inhibition.

Such inhibitions usually being unconscious, the individual himself may not know what it is that handicaps him; and yet in thousands of cases the boy and girl as they come out of school are less efficient and less able to do things in a clear-cut and thoroughgoing fashion than when they enter school as children.

If Watson's conception be correct, then the importance of a thoroughgoing mental examination at school entrance is emphasized. With twenty or forty children, each a bundle of more or less active conditioned reflexes developed in homes of diverse character where children are subjected to many different stimuli, how can a teacher be supposed to act intelligently in discipline and instruction without knowing all that can be learned by expert examination in regard to the results of home training? Plenty of time should be taken for such an examination, and especially important in throwing light on the questions involved would be the study of the spontaneous behavior of the children by a competent expert.

Such thoroughgoing examination of individual children will show that inhibitory conditioned reflexes exist likely to handicap the child not only in school work, but in the development of habits of mental health. We usually call these attitudes, habits, fears, peculiarities, and the like.

With the innumerable repressions and exhortations from childhood—not to do this and not to do that, and to avoid certain forms of speech and certain forms of behavior—it is no wonder that by the time manhood is reached, or perhaps long before, a great accumulation of such inhibitory associations has been acquired; and this more than anything else is the handicap of many individuals. Years ago Dr. James, in his classic paper on the hidden energies of men, gave many examples of men whose efficiency had been greatly increased by some striking emotional experience—a conversion, a love affair, a great shock, or the devotion to a new cult or what not, something that raised the individual to a higher level of activity, and greatly increased his efficiency, so that thereafter he was able to live on a higher plane as a result of the hidden sources of energy that were tapped by the emotional experience, as James expressed it. Probably in many of these cases the real psychology of the individual's improvement was to be found in a removal of inhibiting associations, a release from this result of repressive education, the inhibiting accumulation of a lifetime.

Many most brilliant men and women have their activity limited and their efficiency seriously retarded by such conditioned reflexes, and the remarkable results that occur when by proper training or by shock these conditioned reflexes are broken up and these inhibitions removed have been demonstrated in many cases.

Of more serious inhibitions we have plenty that are more or less pathological. In the experiences of "shell shock" throughout the war, we have innumerable illustrations of such inhibitions. The frequent cure of "shell shock" by a shock of some kind illustrates the way in which such inhibitions can in turn be inhibited by other stimuli if they are sufficiently strong, while the cure of such cases by training, on the other hand, shows how, by many repetitions, inhibiting stimuli and associations may be developed.

The psychiatrists have long recognized that in many cases of nervous and mental disorder the most serious trouble is an inhibition of some kind. Just as one's intellectual ability is often arrested by unfortunate inhibitions—and these may be so deep-seated as to condition the difference between the ordinary man and the man of genius, as Bateson has suggested—so certain inhibitions may be so serious that their presence or absence means the difference between normality and serious mental disorder. Hence, as psychiatrists recognize, the important thing is some means of removing injurious inhibitions.

From the point of view of association and the conditioned reflex, the remedy for unfortunate inhibitions—whether conditioned reflexes, associated ideas, mental attitudes, fear, or what not—may be stated in general terms by saying that it is always possible to remove the inhibition by associating a new stimulus of sufficient intensity with the unfortunate association—that is, to inhibit the inhibition by a new and stronger stimulus. The new reflex or association may be established by shock, or by many repetitions, or by constructive activities in relation to the object of fear or the like—that is, by establishing a system of conditioned reflexes or associations.

This whole matter of inhibition and the widely related aspects of it should, in the light of the results that have been obtained, be studied as broadly and considered as generally as the law of stimulation and what we are apt to look upon as positive association.

Psychoanalysis and the Conditioned Reflex

For psychoanalysis in the technical sense as employed by the psychiatrist in his clinic, or in the lay sense as practiced by a preacher in confession and the like, or by the teacher like Socrates, or by the individual thinker like St. Augustine, or Jonathan Edwards, in meditation, or by the individual patient, as advised to-day by some psychiatrists—for all these, the method of the conditioned reflex has an important contribution. The significance of this has already been suggested.

It is well illustrated in our social relations, or the affective situations of the individual in relation to other individuals and to the social group, especially when we consider the association of ideas and mental attitudes as well as the association of stimuli. Dr. Kempf does not put it too strongly in the following passages:

"The *conditioning* capacity of the reflex is of the utmost importance in determining our selections and aversions throughout life, such as mating, habitat, friends, enemies, vocations, professions, religious and political preferences, etc. We can understand now how we come to have an avertive prejudice for one person, experience, or object because it has qualities that happen to be similar to some of the qualities that another person, object, or experience had that caused us to feel pain, fear, or embarrassment. Similarly we prefer those new things that have some of the qualities of old things that were pleasing and invigorating stimuli."[1]

"It seems naïve to urge that every person, friend or enemy, is essentially a compound stimulus that varies more or less in its gratifying or distressing influence upon an individual, but the stupid resistance to psychoanalysis and the adjustments of repressions makes it necessary. The conditioning of fear, hate, love, shame, sorrow, hunger, occurs without our conscious choice that these affective-autonomic functions should or should not prefer to have or to avoid certain objects, persons, or situations. These mechanisms may often be obscure, but in one respect they are consistent. They are *always determined by experiences.*"

Every one, perhaps, at some time has noticed the peculiar character of his own action or the strange things he finds himself sometimes saying. Many of us have comforted ourselves by the clever explanation given by Oliver Wendell Holmes, who states that such things are to be explained only on the supposition that we have a mental blind spot which sometimes functions so that idiotic ideas of any kind whatever may become associated. Probably many of these cases are to be explained as obvious conditioned reflexes.

We can sometimes detect these mechanisms in concrete and trivial matters, as well as in those more serious referred to by Kempf, but the ordinary person is not likely to notice them.

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[1] See The Tonus of Autonomic Segments as Causes of Abnormal Behavior, by Edward J. Kempf. *Journal of Nervous and Mental Disease,* Jan., 1920, p. 15.

A classical case was given by Betz from his own experience, reported in substance as follows: Riding in a street car one day, Betz saw a man settle himself comfortably with a cigar in his mouth. Just then a slight accident jolted the car and threw the cigar out of the man's mouth in a ludicrous fashion which caused Betz to smile. Some days afterwards, he met a stranger on the street and found himself involuntarily smiling. Then he tried to recall the man, whose face had a familiar look, and the involuntary smile enabled him to do so. The man was the victim of the street-car incident that had caused his amusement.

Here the smile was an ordinary example of a conditioned reflex. The personal appearance of the man seems to have had no essential relation to the humor of the situation; it would have been as ludicrous in the case of any other man. But the appearance of this man became associated with the original situation as a conditioned stimulus and brought the same smile.

Instances of this kind, in which a part of a situation conditions the reaction to the whole of it and also brings about a recall of the original circumstances, are of everyday occurrence. The unfortunate social possibilities in a case of this kind are obvious. Hundreds of people, especially school children, have gotten into trouble by smiling at the wrong time; and the schoolboy is likely to be entirely innocent and quite unaware of the reason for his smiling. Innumerable occurrences in the schoolroom, misinterpreted both by teachers and by amateur Freudians, are probably cases of this kind. The point of view of the conditioned reflex gives a simple explanation of much bizarre behavior and ridiculous speech.

Without attempting any critique here of modern methods of psychoanalysis, one point is so clear that all competent specialists will perhaps agree in regard to it—namely, this hygienic necessity of removing unfortunate inhibitions; and, so far as clearing the field and removing obstacles to healthful mental development goes, it is perhaps not too much to say that the aid given the patient by psychoanalysis in the removal of such inhibitions is the most important benefit rendered.

Without technical language or details, the essential psychology of the mode of procedure may be simply and briefly illustrated in the case of the universal inhibitions of fear.

Probably everybody, especially every child, is handicapped by inhibitory fears of some kind. Such inhibitions may be illustrated by almost any of the common, but often grotesque, fears of childhood. For example, a little girl had heard certain incendiaries referred to as firebugs and had listened to a newspaper account of a terrible fire which, according to the report, was set by a firebug. She thus gained the idea that there were certain insects that set fire to houses, and naturally enough she became afraid of these incendiary bugs, lest her own house might be set on fire. To a child's imagination, an insect like this that walketh in darkness and can effect such tragic results naturally became a secondary cause of fear. Usually a child conceals such fears. If discovered, the method of removing them is simple. But concealed and repressed, a fear of that kind or the inhibition it leaves is liable to cause injury for a lifetime, as every psychiatrist knows. Dr. Rows, of London, told at Bloomingdale[1] of a case of nervous breakdown and insanity in a woman of thirty-five which was traced back to a fright the child received at the age of five from the bogey stories and behavior of her nurse.

Let us take another concrete case: Charles Lamb, in his well-known essay on *Witches and other Night Fears,* says of himself: "I was dreadfully alive to nervous terrors. The nighttime and solitude and the dark were my hell * * *. I never laid my head on my pillow, I suppose, from the fourth to the seventh year of my life, so far as my memory serves in things so long ago, without an assurance, which realized its own prophecy, of seeing some frightful specter." The form of his visitations he attributes to the picture, in Stackhouse's *History of the Bible,* of the raising of Samuel by the Witch of Endor.

Whether the morbid attitude be of long standing or recent, the psychology of the remedy is briefly as follows: One brings the fearful idea clearly to consciousness—lowers the threshold for the idea, as the psychologist puts it. In other words, one brings the child definitely to face the cause of its fear, just as the horse trainer, with soothing words, leads the colt up face to face with what has frightened it. Then one associates a rival stimulus with the fear-inspiring object or idea. In the case mentioned, one would show the child, perhaps, the grotesque and comic aspects of the Stackhouse picture, or convince him that it was nothing but a drawing on a piece of paper similar to what he himself could make—that it represented at most an imaginary object, a make-believe representation. By such a discussion, rival stimuli would be associated with the picture, and after a few conversations of this kind, these associated ideas would inhibit the fear; amusement or orderly thinking would take the place of it. It is always possible to associate a wholesome thought or attitude with the original stimulus as a rival stimulus that shall in turn inhibit the inhibition.

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[1] In a paper entitled *The Biological Significance of Mental Illness,* read at the Centennial Celebration of Bloomingdale Hospital, May 26, 1921.

The practical problem, then, is how to form some association with the general attitude of worry which so many people have, so that as soon as this attitude becomes nascent, it may at once be inhibited by some healthful association. That this can be done and actually is done in many cases we have evidence from many individuals of different classes in society, diverse interests, and varying degrees of education. Apparently it may be any one of a number of things, if only the association be made strong and permanent.

The mere knowledge of the fact that violent change of stimuli causes the fear, this itself may become an associated idea that tends to inhibit the fear. The individual says to the fear-producing situation, "I know the secret. 'I have your number.' With a little easily made apparatus I could do the trick myself." If in no other way, this reduces the fear by the fact that it represents so much coördinated thinking, which, like coördinated action of any kind, is a universal remedy.

Dr. Crile and Dr. Cannon have borne testimony to the fact that in their own cases, since learning the seriously injurious results that come from worry and anxiety, they are able to meet the trying situations of life with greater equanimity. As Crile has put it, the thought of the injury that comes from these emotions is itself a protection against them.

PATHOLOGICAL

On the basis of pathological heredity and often, apart from this, merely from unfortunate environment and bad training and the constant interference of over-anxious parents and nurses and others, unfortunate and pathological reflexes are sure to be produced. Thus the work of education in the schools as well as in the hospitals often becomes, to a large extent, the inhibiting and breaking down of injurious reflexes, or, to put it more concretely, the building up of healthful conditioned reflexes and habits or systems of such reflexes that may inhibit injurious ones. Multitudes of examples could be given if there were time. A few miscellaneous illustrations will suffice.

According to Ibrahim (16, p. 39) the phenomenon that a child shows when he holds his breath is a conditioned reflex of a typical kind. Because of a neurotic temperament or the like, in a fit of passion, perhaps, the child holds its breath once, and this is enough to cause a conditioned reflex. Thus, whenever the child thereafter falls into a fit of passion and crying, the crying becomes a conditioned stimulus for stopping the respiration, and always afterwards, every time the child cries in a fit of anger, he will hold his breath in the same way. This explains a large number of troublesome cases in the behavior of children. It is an easy matter to allow such a violent reaction or inhibition of a normal function to occur, and the association is so intense from the circumstances of the situation that thereafter the child is conditioned, by the act of crying or the sound of his own voice or the like, to an inhibition of the function of respiration. It is interesting to note also that a usual method of cure is to throw water in the child's face or in some way give a shock that will inhibit the inhibition.

In another case cited by Heilbronner (16), a child has to pass by a dog's kennel, when suddenly the dog rushes out barking, without, however, being able to do any harm because it is chained. The child cries, tries to run away, falls, and remains crying and trembling, and is calmed again after a longer or a shorter period with or without any clear recollection of what has happened. The event for the time being remains without any result; but it is noticeable that the child attempts to go around this spot in which the experience occurred. It is thought unpedagogical to permit this timidity; the child is forced to walk again by the kennel; but before it comes into the vicinity of the dog, the attack of fear recurs. Further attempts at education in this direction are given up, but at every opportunity brothers and sisters or playmates tease and laugh at the child for his timidity. The result is a new attack. This occurs more and more frequently and under continually varying conditions with each unpleasant impression—a difficult school task, the denial of a wish, in case of very slight physical indisposition, and finally even on occasion of pleasant events and a pleasant surprise or the expectation of such.

In this example we can trace the way the circle of effective stimuli keeps growing wider—from the repetition of the original situation to the mere mention of the same, and from this to unpleasant situations in general, and finally to events that have nothing more in common with the original conditioned stimulus. Training in action in relation to the cause of fear and the building up of inhibitory associations would have removed this fear. Rasmussen has reported a case that illustrates this.

"When R. was about three years old, she was frightened when an alarm clock, which she had never heard before, suddenly went off. She cried violently. But when a light was made, and she could see the alarm clock and was allowed to make it go off, her fright disappeared, and she quietly submitted to having the light extinguished. All she said was: 'The little clock must not say that, because then R. will be sorry.' In the time that followed, she was not frightened when the clock occasionally went off."

Among a large class of people numerous conditioned reflexes for drugs, patent medicines, or even special kinds of food are often developed. The child cannot get along without his special food or medicine, the adult is the slave of certain definite drugs, and the like. Bad as the drug habit, in this sense, is, nevertheless drugs often seem to have an hygienic effect because they act as associated stimuli to healthful conditioned reflexes.

In many cases the cure seems to be the result, not so much of the remedy given, as of the form in which it is applied. As Heilbronner points out, the psychiatrist may fail in his efforts until he decides to resort to some measure which, as the patient says, has always helped, a remedy recommended, perhaps, by some old shepherd, or an electrical treatment, or the like. As soon as the psychiatrist adopts this method—that is, applies the associated stimulus that has become effective in producing certain healthful conditioned reflexes—the cure is effected.

CONCLUSION

We have discussed merely one or two fundamental aspects of the conditioned reflex. A great many other things must be omitted. The remarkable possibilities of this method, and the opportunity it affords for studying some of the unusual, bizarre, and mysterious phenomena of human behavior, are obvious upon a little reflection. Whenever something unusual and even something apparently supernatural occurs in the reaction of the psychophysic organism, it is well to approach the matter from the point of view of the conditioned reflex before resorting to speculation or invoking the aid of spiritualism, Christian Science, or occult theories of any kind that cannot be verified. There is time for but a single illustration.

Many remarkable cases of so-called dermographism and stigmatization have been reported. The witches of the Middle Ages were reported sometimes to bear the word Satan inscribed in red on their backs, and saintly mystics to have carried the sign of the cross inscribed on their foreheads, or the like. Richet, the French neurologist, has reported a concrete and modern instance of a mother watching her child, who, in play, accidentally unfastened the catch of a heavy sliding door in front of the fireplace and was in danger of being guillotined. In the fright and shock of the moment, there formed on the mother's neck, the part threatened in her child, a red weal that endured for several hours.

The tendency of the human mind is to look upon such phenomena as supernatural. The explanation of some of these cases, however, is obviously suggested by recent investigations of the formation of conditioned reflexes in the vasomotor field. These were carried out by Cytovitch (12) and others of the Russian school, apparently with great care to control conditions, and the results show that vasomotor changes similar in character to those reported can be produced in the laboratory as conditioned reflexes.

Dr. Humphrey (19), in a noteworthy paper in the *Journal of Abnormal Psychology,* has attempted to show how largely the different Freudian mechanisms of transfer, symbolization, conflicts, and sublimation, may be explained from the point of view of the conditioned reflex without resorting to the usual theories of the unconscious. While Dr. Humphrey may have carried his explanation too far, on the other hand why need we resort to special mechanisms to explain those activities that are clearly explained simply by the ordinary principles of associated reaction in the production of conditioned reflexes?

One of the well recognized principles of science, so important in psychology and hygiene that it should be especially emphasized, is the rule accepted from the time of the Middle Ages that, in explaining phenomena, we should not multiply entities; and thus when a simple explanation by a well established scientific principle is supplied, the student should not confuse the issue by resorting to complex and speculative theories, however attractive these may be from their appeal to human emotion or from the high authorities that have advocated them.

The extent to which associated stimuli and conditioned reflexes occur in everyday phenomena is hardly realized even by those who have made special study of them. Nearly all the multitudinous inhibitions of daily life, slips in pronunciation, slips of speech, such as those recorded in the little German book, *Versprechen und Versagen,* all the forgotten memories—names of our friends, names of books, of places, of words that we wish to use and that constantly evade us—all the tantalizing memories that we know we possess, but that will not come when we need them, that are obviously in our minds potentially, but that we cannot recall merely because we always think of something else which inhibits the right memory—all these and many other similar phenomena, and all the various inhibitions of activity—from the stammering in our speech and the halting in our action to the more conscious inhibitions from hundreds of superstitions and the like that paralyze straightforward activity—all such inhibitions, commonplace as they are, are examples of so many conditioned reflexes or associations. So that the aim of mental hygiene to develop fortunate associations and to break down the manifold inhibitions that retard our activity is one that concerns an enormous part of ordinary education and training.

Probably in every act of our daily lives conditioned reflexes are involved. Every habit is probably a system of conditioned reflexes. Watson distinguishes between the conditioned reflex and habit by saying that the conditioned reflex is the element and a habit is a series of conditioned reflexes. It is perhaps better to call a habit a system of conditioned reflexes, as Humphrey does. Every attitude and interest, too, probably involves conditioned reflexes. Thus learning consists in the formation of associations, conditioned reflexes, and systems of conditioned reflexes. Education is a systematic attempt to develop conditioned reflexes that signify normal adjustment to one's environment and efficient activity. In the regular performance of our daily tasks conditioned reflexes and habits should be formed that make for efficiency and also become an anchor to the mental health. The educational and hygienic significance of the conditioned reflex are equally great.

Think of the appalling complexity of the problem of the teacher who has to decide not only what stimuli should be associated with given situations to produce conditioned reflexes and what inhibitions should be developed, but also what inhibitions of unfortunate conditioned reflexes should be developed. The problem for the psychiatrist, in the matter of the reëducation of his patients, is often still more difficult, because of associations that must be inhibited or unlearned.

The contribution of the conditioned reflex to psychiatry is fivefold: first, in giving an objective method for study; second, in showing the elements of one's problems; third, in showing the way to develop healthful associations and to inhibit pathological ones; fourth, in saving one from many erroneous interpretations; fifth, in showing the significance of inhibition, and a method by which injurious inhibitions can be removed.

SUMMARY

1. Apparently, in a child as well as in animals, any stimulus whatever may become associated with another stimulus that occurs simultaneously.

2. Apparently any stimulus whatever associated with sufficient intensity with the original stimulus will produce the same response.

3. An unconditioned reflex is an ordinary reflex. In general terms, it consists in the transformation of a stimulus into a response.

4. A conditioned reflex is one brought about by an indifferent stimulus associated with the biologically adequate stimulus.

5. Any sensory stimulus from any receptor organ may become associated with the biologically adequate stimulus and produce a conditioned reflex.

6. The physical basis for the association that produces conditioned reflexes is a process of neural excitation in the brain cortex. A stimulus coming in from the periphery tends to associate itself with any center that is in a condition of stimulation. The significance of the method is that it is an objective means of studying what occurs in the brain cortex.

7. The brain and mind are active, not passive, in the response to stimuli. Just as in ordinary sense perception a process of selection goes on, so in the formation of conditioned reflexes a selective and differentiating process is functioned by the brain cortex. This is what is called by Pavlov and his students analysis. It is in substance sensory discrimination.

8. This analyzing function of the child's cortex may be greatly reduced on account of various organic and functional disturbances of the cerebrum. So, for example, Krasnogorski observed in the case of idiots and imbecile children that neither mechanical nor thermal nor contact differentiations were possible. In various neuropathic conditions the function of the analyzer shows constant or intermittent disturbances. Differentiations appear difficult in the cases of these children, and have an unstable and indefinite character. In this respect the disturbances in differentiation of the taste and smell analyzers in case of rachitic children are noticeable.

9. Every excitation of a cortical structure brings about always the inhibition of others. The stronger the stimulation of one cortical system, the greater is the inhibition of others. The stronger the inhibition center, the more extended are the irradiations of inhibition. If, therefore, a strong active stimulation focus is present permanently in the cortex, the secondary reactive inhibition can always attain finally such a degree of intensity that its irradiation spreads to the whole cortex. In many nervous systems a moderate focus of stimulation conditions an extremely high degree of inhibition which irradiates extraordinarily quickly and broadly over the surrounding regions of the cortex. On account of this wide irradiation of the inhibition, and on account of the appearance of such intensive areas of arrest, naturally a more or less long-continued depression of the whole cortical activity ensues. This reduction of the cortical activity we are accustomed usually to discriminate as fatigue.

10. Thus cortical fatigue is not exhaustion, but only the reduction of the cortical activity in consequence of a transient, but widely distributed, irradiation of cortical inhibition. A more striking proof of this is the fact that such a general inhibition can be removed at any moment by any new external stimulation of sufficient strength.

11. Sleep is a general mode of arrest of the conditioned reflexes in contrast with other more specific modes of arrest.

12. Pavlov believes that by such investigations as those of sleep one may find the solution of the phenomena of hypnotism and the like. If ordinary sleep is a general arrest of the activity of the higher part of the brain, we can consider hypnotism as an incomplete arrest of various portions of the brain.

13. The law of stimulation and inhibition is briefly as follows: A new and different stimulus affects whatever process is active at the time. If this process is stimulation, it inhibits the excitation. If it is inhibition, the new stimulus inhibits the inhibition.

14. Conditioned reflexes, in contrast with the unconditioned reflexes, are unstable, temporary, always tending to die out if not reënforced by association with the unconditioned

stimulus and subject to inhibition by any chance stimulus from the environment.

15. The child at birth is a paleencephalic organism; the connections between the old and the new brain have not yet been developed, and the individual is more helpless than a dog deprived of his cerebral hemispheres.

16. Very soon after birth, the process of connection of the old brain with the new begins, and the process of association making possible the formation of conditioned reflexes develops early, much earlier than most investigators, perhaps, have realized. The continued development of such reflexes marks the neural development of the child's brain and mind.

17. From psychological investigation, it appears also that the child's innate tendencies and native impulses are simple and his inherited tendencies generic and relatively few in number, so far as emotion is concerned, being, according to Watson, merely the fundamental emotional reactions of fear, anger, and love.

18. It has been suggested that to these innate impulses should be added the impulse to action which shows itself in the young child in the impulse to activity for its own sake, an impulse so generic that it constitutes the matrix from which many so-called instinctive activities are differentiated.

19. While, as already stated, we can distinguish in phylogeny no dramatic beginning of consciousness, we may note that in a general way the ability to form conditioned reflexes marks a tremendously significant epoch in animal evolution. It signifies the advent of the cerebral cortex. It makes education in the higher sense possible. It is fraught with the weightiest possibilities of advantage or of harm to the organism. It means the possibility of education.

20. The education of the child is largely a process of acquiring in the first place conditioned reflexes and then the more permanent associations and systems of conditioned reflexes that we call habits.

21. The great individual differences in children as regards learning are largely differences in the ability to form and to break down associations and conditioned reflexes.

22. One important aim of education should be to preserve

this plasticity of the individual which makes learning and development possible.

23. The conditioned reflexes in feebleminded and defective children are different in character; for example, the neural structure seems to be less plastic, and conditioned reflexes, once formed, are not easily broken down. A similar characteristic of the feebleminded child has been reported from observation. Such a child, once having learned a reaction or a habit, cannot easily change to a different one. This lack of ability to unlearn what has been acquired seems one of the distinctive characteristics of arrest of development.

24. In the acquisition of these conditioned reflexes during the early years of life, we have a record of the development of the special function of the neencephalon significant for psychology, pedagogy, and hygiene.

25. When a conditioned reflex has been established, the original stimulus itself is often reënforced by the associated stimulus.

26. The child is usually unconscious of the conditioned reflex—that is, the response occurs without his knowing why; likewise the child is usually unconscious of the reënforcement of the original stimuli by the associated stimuli.

27. Conditioned reflexes may be removed, as they are sometimes formed: (1) by shock, i.e., an intense stimulus that inhibits the conditioned stimulus; (2) by reconditioning, i.e., by establishing an antagonistic conditioned reflex by many repetitions.

28. As regards its wider relations, the method of the conditioned reflex offers a means of studying objectively the associative and inhibitory functions of the brain cortex and throws light on the association of ideas, mental attitudes, and the like.

29. The association of ideas, mental attitudes, and the like, are of two classes—either adjuvant or inhibitory to the tasks one has to perform. The importance for mental health of developing healthful associations and attitudes and removing injurious attitudes is as great as the development of healthful conditioned reflexes. Practically the same laws apply to both.

30. In accordance with the general principle of science that

we should not multiply entities, but should choose simple methods of explanation of nervous and mental phenomena rather than complex hypotheses, it is well to study all the difficult and perplexing problems of mental hygiene first from the point of view of the conditioned reflex, resorting to other methods of approach later.

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THE ELEMENTARY SCHOOL AND THE INDIVIDUAL CHILD*

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IT is with hesitation that I venture upon remarks in the field of education. In the first place, psychiatrists are accused of curious meddling in so many phases of human activity that even the modest statement of an observation or two not infrequently becomes converted into dogmatic assertions and prescriptions for reform. In the second place, the facts responsible for my remarks at this time are not based on a long or wide range of experience. Accordingly, I trust that what I have to say will be regarded merely as a series of personal impressions, and not construed as an attempt to assume direction over the education of the young.

Perhaps there is no institution of our social organization in which the individual can so easily become lost in the group as in the elementary school. To be sure, we are surfeited with books on the psychology of the child. We speak freely of the backward child, the nervous child, the incorrigible child, and yet it is theories regarding these groups that we take up in actual discussion. In looking over some one hundred advertisements of private schools not long ago, I was impressed with the same type of fact. There was "special attention" given to college preparation, to athletics, to health, to the comforts of home, to culture, etc., but only one school advertised "special attention given to the individual child." I suppose the argument offered in defense is that the school training aims to be ample for the needs of every child. For example, its courses of study have been so carefully prepared and standardized that a child who repeats his grade once or twice must be backward. Or again, the boy who deliberately turns aside from a clean bed and a well-ordered class room to follow a huckster's wagon, or run with the gang on the street, must have the deep-seated waywardness of the incorrigible and delinquent, to act in a way so contrary to the behavior of his fellows. Are these children misfits in the school system because of some innate personal deficiency, such as retardation, neuropathic constitution, and viciousness? In some instances they are, but in many instances the repeating of grades, the temper outbursts, the crying spells, the truancy, are symptoms of difficulties in adjustment arising from a more superficial background. In the dispensary of the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, we examined 143 children during the months of September, October, and November, 1920. One hundred came directly or indirectly from the schools of Baltimore and its suburbs. Of this number, 80 were referred for backwardness expressed by the repetition of grades and uncomplicated by disciplinary troubles. Only 50 per cent of the latter showed actual retardation, according to the Binet-Simon tests. The poor record is class work made by the other 50 per cent was associated with certain facts that can best be discussed by drawing your attention to a bit of study along this line that has been carried on for several years as a sort of by-product of our psychiatric dispensary.

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* Read before the Mental Hygiene Section of the National Conference of Social Work, Milwaukee, June 23, 1921.

In January, 1918, under the direction of Dr. Adolf Meyer, I undertook some work in one of the Baltimore schools (School 76) with pupils who were reported as difficult by parents and teachers. The venture was a piece of private research, quite divorced from any organized activity in the public-school system. The school chosen had been the center of an investigation for the study of feeblemindedness, which Dr. C. Macfie Campbell had made in this locality in 1914. My interest was in the non-feebleminded, though I followed up the complaints as they were referred, without discrimination. Of the 46 children who came under observation, 35 were reported as having difficulty in keeping up with their grades in one or more subjects. In each of these cases where there was a suggestion of retardation, the Binet-Simon test was applied. As a result, 16 of the above-mentioned 35 were found to have a mental retardation of from three to six years. The academic troubles of the remaining 19 were associated with, if not the disguised expression of, such faulty psychobiological reactions as shyness, laziness, inattention, and vicious tendencies, sensitiveness to criticism, daydreaming, hypochondriacal fears with resulting irregular attendance. The 11 remaining from the total 46 were referred for the more overt adaptive difficulties of temper tantrums, sullenness, crying spells, twitching, indifference, excitability, poor coördination with the hands, quarrelsomeness, etc.'[1]

In reviewing the data accumulated, one fact stood out: in practically every case the peculiar characteristics for which the child was referred could be easily traced to their first appearance in the early years of school—kindergarten and first and second grades. In the majority of cases also, the unhealthy habits of adaptation began in the home, and were carried into and through the school life, handicapping the efforts of teacher and child to get together on the business of early training in the class room; and the commonest result of this handicapping was the repetition of grades. Accordingly it seemed best to devote some time to the first grade, with the special object of examining the problem of backwardness at its source.

By way of experiment, 18 children were selected from the first grade for special study. Their ages ranged from six to ten, and their years of repeating the first grade from one to three. These children were studied from the standpoint of the story of the home, the story of the school, and the story of the child himself, as recorded under the headings of complaint, school history, habit data, personality traits, and a rough estimate of physical status as obtained from the health records, weight curve, and brief examination. Aside from the Binet-Simon tests, no special technique was used, either in the examination of the children or in the sifting of facts. The Binet-Simon findings were as follows: In 2 cases the actual age and tested age were exactly the same; in 7 cases there was a difference of only one year between the actual age and the tested age; in 7 cases there was a difference of two years between the actual age and the tested age; 1 case objected so violently to examination that it was thought best not to push matters; and 1 case showed a difference of three years between the actual age and the tested age. It was felt that the difference of from one to two years between the actual age and the tested age of 14 of these children represented no real backwardness, but was the expression of various factors in the background, development, early training, and personality traits of the individual children. That these were the facts responsible for the lodging in the first grade seemed more feasible than deficient mental equipment.

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[1] The details of this study, which was of some fifteen months' duration, were published in MENTAL HYGIENE, Vol. 4, pp. 331-363, April, 1920.

Turning from the facts of standardization to those of physical condition and living arrangements, there was nothing striking in the story of these little people. There was 1 mouth breather, 1 child with definite eye strain, and 2 tuberculosis suspects. Several children appeared pale and undernourished, but only 2 weight curves were below the normal. The habit data were characteristic of this industrial section—comparatively late bedtime, with two, often three sleeping in a bed; a diet of coffee, buns, and soup; movies two nights a week. Unideal as these conditions are, it must be remembered that they have not proved a serious hindrance to the school progress of hundreds of other boys and girls.

The school records of the members of this group varied little one from another. There was the same amount of language difficulty and uneven attendance that is found in the average classes throughout the school, so that here again, as in matters of health and living arrangements, one had to beware of over-emphasis on obstacles that are commonplace in this community setting. The stories of the various children were remarkably similar. John Jones had entered the first grade at six or eight years of age, acquitted himself with a "poor," and been rolled on to another first-grade teacher at the end of a half year, with all the moss of reputation for "dumbness" that he had acquired in first-grade sojourns elsewhere. Not infrequently John Jones and I were introduced by the teacher before the whole class with the remark: "I'm glad you've come to examine John. He can't seem to learn a thing. I don't know what's the matter with him. John Jones, stand up and let the doctor see you."

Naturally the mental attitude of a child who has been passed from one teacher to another for a year or two without promotion is a very interesting study. Some of these children were calloused to ridicule, teasing, and loud rebukes, both at school and at home. Ambition and the spirit of rivalry had gone. They were bored timeservers in the class room, often organizing mild revolutions when the teacher's attention was diverted for a moment. Others covered up a sense of shame at not being promoted by various reactions attributed to their being "high-strung and nervous." They were exceedingly "touchy" over the slightest criticism or teasing, bursting into tears or explosions of cursing at the most trivial provocation. Still others seemed to have sunk into an uncommunicative state, never volunteering a remark and rarely answering a question, but quietly amusing themselves in a way to escape contact with the environment as much as possible. The general characteristics of the group and the personal traits of its individual members were so interwoven that in many instances it was impossible to say how much of the child's behavior was due to temperamental idiosyncracies and how much was a defense mechanism developed to meet the school existence. Each child had his own story of shyness, obstinacy, sensitiveness, fear, laziness, etc., which undoubtedly played a large rôle in his failure to make a good start in school.[1]

Following the gathering of data on the above group, it was arranged with the principal of School 76—Miss Persis K. Miller—that these repeaters be put under the supervision of a teacher who had the time, patience, and skill to see what could be done with the 18 candidates for reconstructive therapy. Such a teacher was kindly given us by Dr. West, Superintendent of Baltimore Schools, and she began her work September, 1920. In January, 1921, she reported that 10 of the class were doing good, steady, second-grade work; 7 were making satisfactory progress in the first grade; and 1 seemed impossible to modify. At the close of the school year—June, 1921—all of the above-mentioned 10 qualified for third-grade work, and will go into ordinary third-grade classes this coming fall. The remaining 7 qualified for second-grade work, and will go into regular classes at the beginning of the coming school year. Only 1 child of the class of eighteen failed to respond to special study.

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[1] A sketch of the detailed examinations of the separate cases appears in the chart accompanying this paper. See pages 720-723.

Eight of the 10 children who made the second grade in January, 1921, and the third grade in June, 1921, had repeated the first grade at least twice before entering this special class in September, 1920, and according to the Binet-Simon tests 7 of these 10 children showed a difference of from two to three years between their actual age and tested age; 2 showed a difference of one year between these ages; and 1 child had an intelligent quotient of one hundred.

Before passing on to a discussion of the above results, I want to outline the problem involved in two or three cases:

E. B. (No. 4) was a boy of ten when I first saw him in March, 1920. He was referred by some three first-grade teachers as "decidedly retarded." He had entered school in the first grade at six years of age, and was still lodged there in his fourth year of school attendance. Aside from his supposed stupidity, the reports of him were colorless. He idled away his time in school without doing anything worse than staring out of the window, whispering, and occasionally giving some other child a sly punch. No teacher had ever been able to get a "rise" out of him by threatening, scolding, ridiculing, or keeping him after school. What he learned to-day was gone to-morrow. His mother finally became reconciled to his failure in promotion, ascribing it to "nervousness," a term that the boy was glad to carry around in self-protection.

Examination: E. B. was a clean, well-nourished boy with good living arrangements. He had drifted into the habit of auto-erotism, unassociated, however, with any particular reaction. There was no shyness or embarrassment. He answered questions promptly and with affability. According to the Binet-Simon tests, he had reached a mental age of eight years. There was a marked attention difficulty, with a tendency to guessing and jumping at conclusions. It impressed one as the product of laziness and chronic lack of interest and initiative rather than of natural defect. He had the appearance of being profoundly bored and indifferent. At recess he stood around the yard, not having energy enough to remove his hands from his pockets and bully a younger boy. His mental attitude was expressed by the statement: "I don't work because I'm too nervous." In what way are you nervous? "I don't know. Mother says I am."

Process of Modification: This boy was the hardest problem of the group from the standpoint of modification. To hold his attention for five minutes, it was necessary to stand over him with the most intimate supervision. Any attempt to push him was met by fear of collapse on the part of the mother. However, as soon as the latter realized that her boy could learn if he would, she became enthusiastic in coöperating with the teacher to eliminate the "nervousness" and bring E. B. up to the standards of which he was capable. The child also gradually awoke to the fact that he could learn, and is apparently gaining enough satisfaction from achievement to keep up with the work of the second and third grades to which he has been promoted. In bearing he is more alert and straightforward, playing naturally with other children. The auto-erotism has not been observed for six months.

M. M. (No. 8) was a girl of nine when I saw her in March, 1920. At that time she was repeating the first grade and not making much progress even on the second trial. She was born in the mountainous section of North Carolina, and lived there till the death of both parents from influenza in 1918, when she came to an aunt in Baltimore. Between the ages of six and eight, she had attended country school irregularly, but apparently had not picked up enough to help her much in the first-grade work of a city school. Her home environment was excellent so far as living arrangements were concerned. She was the only child in the home of an aunt in comfortable circumstances. The aunt was not only kind to her, but was so anxious to compensate for the inferior advantages of the past that she was constantly pushing and prodding M. M. into new activities—speaking pieces in Sunday school, joining children's parties, and taking a front seat in situations that almost stampeded the child's social resources. In school the teachers said that M. M. was dull and had a tendency to be sullen and obstinate when criticized. If pressed to some task, she would bury her head on her desk in tears.

Examination: M. M. was a painfully shy little girl, ruddy and well developed. She was about twice the size of her classmates, and when she got up to recite, she was so self-conscious that the children were obviously amused. Even while we were talking quietly in a room by ourselves, she hung her head in embarrassment, and her answers to questions were scarcely audible. According to the Binet-Simon tests, she had a mental age of seven years plus, but one felt reasonably sure that the difference of two years between her actual age and tested age was to be accounted for by the psychobiological reactions of sensitiveness and fear described above.

Process of Modification: The aunt was seen, and her coöperation readily elicited. It was suggested that M. M. be left to herself so far as artificial attempts to promote initiative were concerned; that encouragement and as little anxious watching as possible be substituted by aunt and teacher for continuous prodding of the child to a pace incompatible with her feelings of satisfaction and enjoyment. The plan worked well. Gradually she began of her own accord to reach out after people and things. She began to melt into the class group, to get pleasure out of working with some one else, and to play with other children for the fun of it. At the same time her shyness disappeared. She became friendly with the teacher, seeking her out with all sorts of questions. The sullenness, obstinacy, and crying spells have long since ceased to exist. In January, 1921, M. M. made the second grade, and in June, 1921, she passed easily into the third grade. Here again the whole appearance of this child has changed. She is frank and open in manner, talking freely with the ordinary chatter of her age. On entering the class room, one sees her halfway out of her seat, bursting to volunteer in some exercise, when a year ago she almost sank to the floor with confusion over a simple question.

J. B. (No. 3) was a boy of eight when I saw him in April, 1920. At that time he was finishing his second year in the first grade without hope of promotion at the end of the term. He was described as "hard-headed and plain stupid," and he certainly looked the part. He was born in Russia, and had come to this country as a child of two or three. He lived in an overcrowded home, sleeping with one or two others at night, and retiring "from eight o'clock on." His diet was chiefly coffee and buns. English was rarely spoken at home. At six years he had entered the first grade, two years of which had left little if any impression on him. In play he got on badly with the other children, being inclined toward rough-ness and picking an easy quarrel. In class he could rarely be induced to recite, usually getting no farther than rising to his feet. He did not behave in any extraordinary way that showed embarrassment or anger.

Examination: In appearance J. B. was a thick-set boy, with round, closely cropped head and heavy features over which emotional play was infrequent. There was no spontaneous conversation, nor yet any hesitancy in answering questions. According to the Binet-Simon tests, he had a mental age of six years plus. During this part of the examination, as well as in general conversation with the child, two things stood out: first, a noticeable difficulty in grasping an idea and second, a mental attitude of fundamental shyness and reserve that was quite buried beneath a rough, burly exterior. The slowness in taking in an idea was partly temperamental and partly associated with the fact that at home he is not accustomed to hearing English. However, instead of asking that the question be repeated and explained, J. B. went ahead and gave the best answer he could to his conception of the query. This behavior was probably due to shyness, and also to the fact that questions and answers were for him a matter of command and obedience, without comment. At home he was soundly punished if he displayed too much initiative in discussing parental requests. His attitude toward teachers and others in authority was that of mild suspicion. They were just other persons to get ahead of. At heart he was afraid of them, keeping to himself and thanking others to let him alone. The mother reported that beating him brought no results.

Process of Modification: With the characteristic modesty of a psychiatrist, I left the prescription for drawing out J. B. to be compounded by the teacher of the special class, giving her only the few impressions I have mentioned above. How she did it I do not know, but this little boy has been thawing visibly since she took him in hand last September. January, 1921, he made the second grade, and this month has passed into the third—a fact of which he is extremely proud. Better yet, he gives evidence of making progress in social contacts. He holds his own in games and in class competition, and meets the give and take of life affably and without friction.

These three cases give some idea of the eighteen varieties of problems that confronted the teacher of this special class. In the children as a whole, she ran across several more. For example, the members of the class had no conception of working together in a group. By virtue of certain personal traits, they had always stood apart from their fellows in work and play. Each wanted something different—one to talk aloud, another to be left absolutely alone. The only point on which they were united was that of instant rebellion to seat work of any description. (It seems that in previous school existences these little folks had been given tasks with pencil and paper to keep them quiet, but upon their productions nobody had ever cast an eye even of disapproval.) Another source of perplexity was the utterly demoralized condition of attention habits which the class displayed. If it was hard to get and to hold the attention of the individual members, it was far more difficult to get the attention of the group. Had the teacher done nothing more than help these children acquire habits of working together with harmony, contentment, and satisfaction, she would have accomplished a great task. On entering the class room at the present time, one finds children who have learned the joy of achievement. They want to sing you a song, to show you the illustrations of a story that they have hung around the bare walls of their room. They ask you to stay and hear a reading lesson. But this teacher has done something more from the standpoint of academic record. She has brought seventeen chronic first-grade repeaters up to the standard requirements, enabling them to go on into second and third grades with ease and satisfaction, and she has demonstrated the fact that children who repeat grades in school are not necessarily retarded in mental capacity.

To what have these results been due? Before giving my own impression of the matter, let me say a word about the school background of the above experiment. For several years School 76 has been studying the problem of repetition in its midst. For three years a special health worker, privately financed, devoted her whole time to following up minor ailments—common colds, post-contagious-disease conditions, and any other factor influencing regular attendance. The result was an attendance record of from 96 to 98 per cent, but the repeating of grades remained *in statu quo.* This same worker directed a campaign towards the relation between progress in school and the clearing up of tonsils and adenoids. The results, over a period of three years, were that 50 per cent of the children operated on showed no difference in their school work, 25 per cent showed some improvement, and 25 per cent appeared to make a poorer showing than before operation.

The plan tried in the first three grades of dividing the class so that each half of a room rotates between playground and class work resulted in a certain amount of gain in school progress, due to the fact that each teacher worked with smaller groups. It did not, however, eliminate repeaters such as have been described above, the majority of whom had been accorded the benefit of the scheme just outlined.

In view of these facts, it would seem that the success obtained with the experimental class was due not so much to the extra time spent on them as to the fact that this time was devoted to a study of the individual needs of these children. Here were 18 school failures according to the criterion of grading, and 18 individuals whose pedagogical record and Binet-Simon findings would be credentials enough to admit them without question to that mysterious order called "the backward child." They could not be poured into the ordinary mold of school curriculum because of certain traits of personality that had to be discovered, understood, and wisely handled. The same psychobiological characteristics of shyness, indolence, fear, sensitiveness, daydreaming, etc., acted as conflicting factors in the Binet-Simon tests, obscuring the native capacity to such an extent that a difference of from one to three years appeared between the child's actual age and tested age.

A year of school training directed by an understanding of these characteristics has resulted in restandardization data with the Binet-Simon tests in June, 1921, that run parallel with the academic progress of these children as recorded in their grading reported above. The 7 children who showed a difference of two years and over between their chronological age and mental age according to intelligence tests made in March, 1920, now show a mental level that coincides with their actual physical age.

In conclusion, I would go back again to the problem of what is being done in the elementary schools for the child whose adaptive difficulties are such that he cannot assimilate the regular training without such special lifts in the way of individual understanding as I have outlined above. The psychiatrist would probably not make it his business to raise the question or wrestle with its answering, were he not daily confronted in dispensary and private practice with concrete issues of this sort. The 100 school children referred to as passing through the dispensary of the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital last fall are illustration enough. By the time they come to us, however, they have not infrequently been consigned to that heterogeneous gathering of misfits known as "the ungraded class," there to remain till the law releases them to enter the working world. With years of repeating behind them, and a mental attitude of disgruntled tolerance of their situation, we find an intelligence quotient of 80 and over. It is no wonder that the school is aghast over our report that the poor academic record is probably the result of a bad adaptive start, rather than of mental retardation. From a pedagogical standpoint, the remedy would seem to lie, not in ultra-standardization of curriculum and the infusion of more interests and activities in the program, but in creating opportunities for teacher and child to understand each other. In School 76, we are attempting a practical application of this theory by seeing to it that the child gets a good start in the first and second grades. For example, out of 150 first graders during this past year, 30 laggards and irreconcilables have been culled for special study. (Eighteen of this number were spending a second year in the first grade, and 12 of the remainder were destined to fail in promotion.) On actual examination, there were but 4 retarded children in the group. The troubles of the other 26 were akin to those described in the class of 18. Smaller classes and closer supervision of the first- and second-grade teaching are to be the tactics employed in this particular situation.

And for those of us who examine such children, there is subject for reflection. Are we using the Binet-Simon scale as a yardstick to measure off lengths of intelligence, or are we using the tests as a help towards the sizing up of individual child problems? Are we confusing the term "mental age" with a diagnosis of the home situation in question? Do we see the personality with its setting of life story behind the intelligence level? These are possibilities of view that at times seem strangely remote from the productions of psychiatrists and practicing psychologists. As such, we should beware of agitating ourselves to decimal points of determination concerning qualifications for the groups of subnormal and dull, lest the object of our research becomes buried beneath this mound of his own case.

In concluding this resumé of modest beginnings, I want to thank Dr. Henry S. West, Superintendent of the Baltimore Public Schools, for permission to carry out these studies. The credit for their result belongs to Miss Persis K. Miller, Principal of School 76, and to Miss Gertrude Soran, teacher in charge of the experimental class. Without their enthusiasm, skill, and inexhaustible patience, the research could never have been accomplished.

CHART OF SPECIAL CLASS, SEPTEMBER, 1920–JUNE, 1921

Number	Age	Binet-Simon	School grading	Physical status	Habit data
(1) A. A.	8	8	Beginning 3rd year in 1st grade.	Satisfactory.	Poor eating habits.
(2) B. W.	7	6+	Beginning 2nd year in 1st grade.	Slight speech defect.	Sleeps 3 in bed.
(3) J. B.	8	6+	Beginning 3rd year in 1st grade.	Ruddy. Well nourished.	Coffee-and-bun diet. Late bedtime.
(4) E. B.	10	8+	Beginning 4th year in 1st grade.	Healthy.	Living arrangements O. K. Anxious mother.
(5) G. A.	7	Uncoöperative to test.	Beginning 2nd year in 1st grade.	O. K.	Satisfactory.
(6) M. L.	8	6	Beginning 3rd year in 1st grade.	Pale, uneasy child.	Poor food. Neurotic mother.
(7) M. E.	8	5+	Beginning 4th year in 1st grade.	Tuberculosis suspect Eye strain.	Late bed. No home care.
(8) M. M.	9	7+	Beginning 2nd year in 1st grade.	O. K.	Excellent.
(9) N. E.	9	7+	Beginning 3rd year in 1st grade.	O. K.	Neurotic family setting.
(10) L. J.	6	5	Fifteen months in 1st grade.	Seems good.	Bed wetter.
(11) R. H.	9	7	Beginning 3rd year in 1st grade.	Mouth breather; underweight.	Good home setting.
(12) R. W.	8	6	Beginning 2nd year in 1st grade.	O. K.	Poor home setting; irregular attendance.
(13) S. P.	8	6	Beginning 2nd year in 1st grade.	Two pounds underweight.	Poor food.
(14) S. L.	8	7	Beginning 3rd year in 1st grade.	O. K.	Movies four times a week.
(15) S. W.	6	6+	Beginning 2nd year in 1st grade.	Ten pounds underweight.	Sleeps 3 in a bed. Late bedtime.

PROGRESS NOTES, JUNE, 1921

Personality traits			School grading	Binet-Simon	Subsequent data
Leans on others. No self-confidence.			3rd grade.	Not retested.	Independent worker. Full of initiative.
Lazy; chronic guesser; easy-going.			2nd grade.	Not retested.	Good attention habits. Some spirit of competition.
Shy, awkward, self-conscious; home punishment for stubbornness.			3rd grade.	9 (age 9).	Affable; good mixer. Has "loosened up" all around.
Marked guessing reaction; poor attention; lazy, indifferent, auto-erotic.			3rd grade.	10+ (age 11)	Ambitious; good attention; auto-erotism not apparent; better mixer.
Painfully shy; tearful when pushed beyond own pace.			2nd grade.	Untested.	Has responded well to drawing out. Still shy except with teacher.
Worried, anxious, ashamed of failures; sensitive to point of tears.			3rd grade.	8+.	Happy and contented in work. Proud of progress. Plays naturally.
Guessing reaction; poor attention; quarrelsome.			3rd grade.	10 (age 9)	Attention recovery; competitive spirit; transferred to open-air class for better hygiene, April, 1920.
Shut-in; guessing reaction; shy; temper storms followed by sullen periods.			3rd grade	9+ (age 10)	More normal in general reactions.
Talkative; given to guessing reaction; inattentive.			3rd grade.	10+ (age 10)	More stable and dependable in every aspect.
"Always so quiet;" "under dog" at home; no school friends.			1 A grade.	6 (age 7)	Little response to teacher's efforts. Child silent with no special emotional reaction. Question of genuine retardation.
Excitable; demoralized attention habits.			3rd grade.	9+ (age 10).	Steady worker; good home coöperation; a notable progress in general development.
Quiet, sensitive, serious make-up; painstaking.			2nd grade.	8 (age 9).	Out of school with diphtheria till January, 1921. No home coöperation.
No play characteristics; shy.			2nd grade.	8 (age 9).	Better mixer; coming out of his shell with encouragement.
Lazy, good-natured, indifferent.			3rd grade.	Untested.	Good progress in interest and group spirit.
Bright, alert; rushed into school too early.					Left school January, 1921, for active tuberculosis. Teacher says he could easily have made 2nd grade.

CHART OF SPECIAL CLASS, SEPTEMBER, 1920–JUNE, 1921—*Concluded*

Number	Age	Binet-Simon	School grading	Physical status	Habit data
(16) W. B.	7	7	Beginning 2nd year in 1st grade.	O. K.	Poor home setting.
(17) Y. P.	8	7	Beginning 3rd year in 1st grade.	O. K.	Sleeps 3 in a bed.
(18) J. Z.	7	5	Beginning 2nd year in 1st grade.	O. K.	Good living arrangements.

PROGRESS NOTES, JUNE, 1921—*Concluded*

Personality traits			School Grading	Binet-Simon	Subsequent data
Stolid, unimaginative.			2nd grade.	Untested.	Developing slowly; more emotional expression and interest.
Careless, indifferent, talkative; social joy.			3rd grade.	10 (age 9).	
Shy; sensitiveness; odd behavior; seclusive.			2nd grade.	Untested.	Owing to mother's death, child was put into orphan asylum, May, 1921.

EXTRA-MEDICAL SERVICE IN THE MANAGEMENT OF MISCONDUCT PROBLEMS IN CHILDREN*

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PRACTICAL experience in the management of the problems that present themselves in a psychiatric clinic forces an early recognition of the fact that for the most successful therapeutic results the assistance of non-medical agencies is of prime importance. Physicians in charge of clinics have turned to the social worker for this assistance, which makes it well to consider why it is that the social worker is preëminently fitted to assist the psychiatrist in the adjustment of these difficult problems of maladaptation. It is my purpose in this paper to answer that question by showing some of the outstanding opportunities by means of which extra-medical service can be of indispensable value in the management of conduct problems in children.

For two years we have had a mental-hygiene unit in connection with the Vanderbilt Clinic, under the able leadership of Dr. Bernard Glueck. One of the aims of this clinic has been to furnish a practical teaching center for the training of psychiatric social workers engaged in study at the New York School of Social Work. The results have been gratifying from two points of view.

First, through the medium of this mental-hygiene clinic, the workers have received an experience in handling cases of maladjustment and misconduct. The clientele of a clinic of this kind includes widely varying types of cases, with all gradations of maladjustment, ranging from the very simple problems of faulty parental understanding to the more serious forms of mental disease. A field of training presenting such a rich variety of problems supplies the student worker with a more comprehensive experience in mental-hygiene work than could be obtained in a state hospital, which deals largely with the end results of mental disease rather than with maladjustment in its incipiency. Also, in the pursuit of these studies in adjustment, we have often found that the situations met with were not only germain to psychiatric practice as such, but paralleled those found in all case work dealing with human problems—those of the family, child placing, and the like. Thus we were led to appreciate the importance of mental-hygiene problems in all case work.

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* Read before a joint meeting of the Mental Hygiene and the Family Section of the National Conference of Social Work, Milwaukee, June 27, 1921.

Second, we found that in the adjustment of the patient, the continuous and coöperative assistance of the social worker became a forceful therapeutic agent in carrying the case to a satisfactory conclusion.

It might be well to ask ourselves, then, before entering the discussion of actual concrete situations, what are the aims and tasks of the social worker. And within the purview of this question I should include all social workers; for I feel more and more strongly convinced that experience in this field of psychiatric inquiry, containing as it does a wealth of mental-hygiene principles applicable to every branch of case work, should be made a basic foundation in the training of all social workers. It is to be hoped that before many years we will no longer divide social workers into specialized groups, considering the psychiatric branch as an entity apart—except in so far as special problems will always require the specialist and will attract those whose interests are primarily in this field—but that a thorough training in mental hygiene will be included in the equipment of every social worker, that she may be the better able to understand and adjust the problems that she will meet in actual practice.

What, then, shall we conceive as the fundamental task of the social worker engaged in the handling of cases of maladjustment? First and foremost, it is the determination of the motives that lie behind acts—the discovery of the key to each individual problem of misconduct presented. The first step toward this goal is the collection of all the material available with regard to the elements in the child's life that might tend to shape and influence its development. By means of these data, interpreted with the aid of the psychiatrist, the worker will gain an insight into the forces that make for success and failure in the particular case in question.

These intimate studies, too, will enable the investigator to make a valuable estimate of conditions in the home, and if we accept the fact that the problem of the mental case is not confined to the patient alone, we will appreciate how necessary it is to have an adequate picture of the home setting. Without such a picture it is impossible to determine how changes can best be effected in the maladaptation of the patient, through the application of well organized, constructive guidance and wise foresight rather than by moralizing about his difficulties. I say moralizing, because formerly the amateur worker attempted to solve these problems on an emotional basis, unconsciously using social work, no doubt, as a means of gratification for her own repressed emotional cravings. In this connection, I am reminded of a well-meaning social worker attached to one of New York's large churches, who brought a thirteen-year-old boy to the clinic with the request that he be sent to a reform school at once because he was a crook. It seems he had stolen seventeen cents out of the Sunday-school box and had "almost stolen twenty-three cents."

If we are to direct the progress of any given problem to the best advantage, we must make a thorough study of the personality of the patient, that we may be able to estimate human values aright. This involves a knowledge of the individual's native and acquired equipment—an understanding of his inherited traits and an evaluation of his special aptitudes and handicaps. This one aspect of the case alone will furnish us with a powerful means of combating failures of adjustment.[1]

Our study should include also a careful estimate of the family. Formerly investigation of this sort stressed the physical aspect, but we have now come to recognize the preëminent importance of the psychological elements existing in the relationships within the family unit. If we are to modify or reshape the original desires and strivings of the patient by education, we must recognize some of the possible

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[1] Any one not familiar with Dr. Augusta F. Bronner's book, *The Psychology of Special Abilities and Disabilities*, would do well to read it, as it is an admirable presentation of this subject. Published by Little, Brown, and Company, Boston, 1917. 269 p.

sources of conflict or failure in his attempts at adjustment to life. Thus we are early led to realize that *dissatisfaction* which becomes reflected in the patient's attitude may be the result of a specific reaction to his surroundings.

In the consideration of the possible sources of these dissatisfactions, let us first discuss those that may exist in the home. The social worker, through her many possible contacts in the home, has an opportunity to gain a better knowledge and insight into this side of the problem than the psychiatrist himself. Indeed, the psychiatrist is largely dependent upon the worker's ability to gain a true picture of existing situations through the many sources of information available to her, since without such knowledge, it is impossible for him to give really constructive help to the child.

I feel sure that it is a rather common experience for us all to find situations in which the child either fails to recognize the true source of his dissatisfactions or, if he does recognize the key to his difficulty, withholds the distressing information through a false sense of pride, which makes him feel that the discussion of family relationships is dishonorable; or he may fear possible punishment by an irate parent who is perfectly willing to concede that the child is "nervous" and in need of mental-hygiene care, but utterly refuses to accept any personal responsibility in the matter.

This type of situation is well illustrated by the recent case of a twelve-year-old boy brought to the clinic because he was "nervous," stuttered, and had been displaying some asocial tendencies—such as lying, petty stealing, staying out late at night—for the past two years.

The boy was a quiet, sensitive fellow, small for his age, with only fair muscular development, but of good average intelligence. School progress was fairly satisfactory; he was doing acceptable seventh-grade work, although in recitations he was handicapped by stuttering. At the first interview, little subjective information could be gained from him, but through the history obtained by the worker, the suggestion of an antagonism between the boy and his father was brought out. This explained the failure to persuade the boy to talk frankly at the clinic, since he was accompanied there by his father. Subsequent talks revealed the fact that for the past two years the boy had felt a growing antagonism in his father's attitude toward him. This is rather illuminating in view of the fact that the father reported that the boy's present nervous trouble had begun about two years before. Gradually the boy had come to believe that his father disliked him. He felt that he was always the one to be punished in case of doubtful responsibility, and he found it impossible to talk things over because his father immediately lost his temper. He expressed this by saying: "He always hollers on me when I'm around, and so I don't stay in the house when he is there." Gradually the boy developed a sense of irritation toward his father. He would not ask him for money because he felt that his father would refuse to grant any of his requests. In consequence of this attitude, he accepted the precepts of the neighborhood gang as the most satisfactory for his purposes. He did some stealing, lying, craps shooting, and often stayed away from home at night until he was sure his father would be in bed and asleep.

Discussion of these difficulties with the father was at first met with denial and some antagonism, but gradually he conceded that there might be truth in the suggestion, for he had already recognized that the boy stuttered much more when he was about, and finally he admitted that his own nervousness, frequent outbreaks of temper, and loss of patience did tend to increase the boy's difficulties. There were numerous other elements tending to contribute to the boy's maladjustment which are not pertinent to the immediate discussion, but as a result of the father's change of attitude and his new approach, very satisfactory progress can be reported.

In a consideration of the possible sources of dissatisfactions arising from the home environment, we are frequently forced to recognize the potency for evil lurking in the extreme dependence of the child upon the parent. The end results of this relationship we find in adult neurotics, in whom we discover evidences of an early father-daughter or mother-son dependence which has continued to exert its influence throughout the life of the individual and, through its unconscious force, has determined the choice or non-choice in marriage, with consequent unhappiness and dissatisfaction and the resulting train of neurotic symptoms. It is thus pertinent that we recognize in the adjustments of these children the necessity for the early establishment of a well-balanced relationship between child and parent, such as will permit the individual growth and gradual emancipation of the child.

Again, the relationships that exist between children in the same family may produce situations that furnish food for dissatisfaction. Consider, for example, the problem of the eldest child. If he has been the sole interest of fond parents for a period of four or five years, the advent of another child in the family is a distinct insult to his ego, and he finds that he must make some fairly radical adjustments to the new scheme of things.

A case in point is that of a five-year-old boy whose mother brought him to the clinic because he had become a troublesome conduct problem. He utterly refused to obey, despite severe punishments; he would strike and pinch the baby of one year, so that the mother dared not leave them together unattended; on the street he refused to play with other children, but took delight in pushing the younger children off the curb or taking their toys to destroy or throw them away. The boy confided in conversation: "I hate that baby sister—she is no good. I'd like to kill her." A very truthful statement made by a child who recognized that the presence of the sister entirely changed the even tenure of his existence as a demigod in the household.

We are next led to consider the problems of the middle child, who perforce compares himself with the eldest, to whom falls the recognition of superior age and knowledge, with its concurrent responsibilities in matters of conduct among the others, including himself. In consequence, he conceives his position as being less enviable—that of the underdog. At the same time he may feel that his place in the household is less desirable than that of the youngest child, who receives greater care and attention, it seems, than was ever accorded to him—the step-child, as he comes to believe. In these cases we often find that the middle child gradually develops a grudge attitude which may manifest itself in certain troublesome asocial tendencies, such as lying, stealing, bed wetting, running away, and the like, and it is a frequent experience to have the parent confide that this particular child is a source of more worry and anxiety than all the rest of the family put together. In the study of the cases belonging to this group, therefore, it is essential that we seek the motive behind the conduct. And often we will be forced to recognize the fact that the asocial behavior has a distinct value to the child as a means of putting himself across. He finds that as a result of this display of conduct he does receive attention, and it is attention of one kind or another for which we all blindly strive.

In the problem of the youngest child we have two forces at work. One is the struggle of the child to emulate the standards set by the other members of the family. A common example of this is the desire to follow in the footsteps of a brother, possibly in the matter of attaining success in athletics; and if the younger child is handicapped by some physical weakness and is unable to gain the success for which he strives, there are two directions in which he may turn—the constructive one, by means of which he finds adequate compensation through achievements along some other line, and the destructive one, repeated attempts in an impossible direction through which his sense of inadequacy is gradually increased. The sense of inferiority that he may develop because of his inability to make satisfactory adjustments will often produce a varied train of reactions, from the simple expression of dissatisfaction through misconduct to the more severe grades of mental maladjustment.

The second potent force likely to be at work in the adjustment problem of this youngest child is the influence exerted by the mother in her unconscious attempt to retain her baby; the retention of the child in this essentially infantile state of dependence furnishes a certain type of mother eminently more satisfaction than she can gain by allowing him to grow up and thus losing him. Often the mother says, when faced with this problem: "But what shall I do without a baby? I'll no longer be needed in the world." It is the task of the social worker in such cases to show the parent a better method of gaining satisfaction which will save the child from a possible fixation at a level that will tend to prevent his functioning in later life as a successfully integrated individual.

Another powerful source of dissatisfaction in the home is the problem of sex, as Dr. Healy has so ably pointed out in his study of the problem of conflict as a result of actual sex experience and how it can contribute to misconduct. But there is still another aspect of this problem—that of the parents' attitude towards sex. Often, because of unsatisfactory adjustments in their own sex lives, the parents find it difficult to assist the child to gain a normal concept of this subject. To protect themselves from discomfort, they make the subject taboo. They meet the child's questions with evasions, refusing to realize that he is bound to get his information from some source and that if they do not supply it, the experiences of the street will give it to him in a less acceptable form. Then, too, this consistent prudery on the part of the parent tends to instill the same attitude into the child, so that he or she may later find that it is impossible to face these sex problems squarely. Some excellent examples of this might be given, but space will not permit.

What, then, are some of the principles of treatment that must be employed by the worker in meeting these problems in the home? The question naturally arises, if it is the home environment that is responsible, why not move the child into new surroundings and give him a chance?

On the surface, this would appear the simplest solution, but there are some very serious objections to this method of treatment, in consequence of which it should always be reserved as the last resort. In the first place, it may always be possible to readjust the home situation through the education of the parents and the child. It must be remembered, however, that to do this will require time and earnest effort on the part of the worker, and that it can be done only by workers employed by organizations with a broad enough vision to appreciate that it is not the quantity of cases handled, but the quality, that counts. One worker cannot possibly be expected to carry forty or fifty active cases and give each one an adequate amount of time and thought; the maximum of active cases should never be higher than fifteen. To this the objection of expense may be raised, but the proper adjustment of these cases in early life constitutes constructive work—and the old maxim that an ounce of prevention is worth a pound of cure applies here most forcibly; money well spent in a constructive program will not have to be spent in the care of adults in custodial institutions of one kind and another in later life, a point worth considering both from the economic and the sociologic point of view.

The second point to be considered in retaining the child in his home surroundings is this—in so doing you assist him to form the habit of facing trying situations rather than stepping out from under them. The importance of this point will be obvious when you recall that the "golden period" of habit formation is childhood.

Third, in removing the child from his home into surroundings possibly higher in the economic scale, you must always bear in mind the possibility of his return at some time in the future. In such case, it will be necessary for him to make a twofold adjustment, often accompanied by a new dissatisfaction due to the low economic standards of his family.

Among the principles of treatment, we conceive as of prime importance the education of the child in better habits of adaptation to the realities of life. In his attitude toward the family, he should be made to feel that he is one of a unit, the household; that for the satisfactory functioning of this unit his coöperation is necessary, and that it is his responsibility to contribute his part. He should be helped to form habits of frankness and honesty toward his parents and the members of his own family. Out of this will come a new social sense of responsibility to his playmates, his teachers, and the community at large. He must be instructed in the means of overcoming faulty habits of eating, sleeping, etc., and gain a sense of responsibility toward himself.

The second great problem of education is that of teaching the parents of the child. They must be made to realize that in order to train the child, they must first train themselves, for from the viewpoint of social psychiatry education involves every member of the immediate household. They must be made to realize that their personal sentiments may seriously hamper the child's development, inasmuch as they are bound to fail to hold an objective, impersonal point of view in meeting the issues in the child's everyday life if they make decisions based upon their subjective feeling rather than upon objective reasoning.

It is important that they be taught to realize the necessity of emancipation for the child and that they be shown how best to assist the child in developing habits of independence and of self-reliance in matters of dress, companionship, recreation, etc.

They must be taught to bear in mind the suggestibility of childhood and to recognize the fact that a child reared in an atmosphere of semi-invalidism, of headache, and other distressing symptoms tends to develop like manifestations.

We must always remember that the problem of the child may be due largely to the nature of his reaction to an unintelligent home situation, and that his nervous manifestations may be an attempt to adapt himself to his environment.

The second great source of dissatisfaction, which I will consider very briefly, may be found in the neighborhood setting.

The child may, for reasons physical or personal, fail to put himself across with the other children; he may find that he is on the outside of the ring and may react to this unfortunate situation either by becoming antagonistic and a bully, spoiling the fun of the others, or by withdrawing within himself and gradually finding that his own thoughts, which he peoples with dream children, make the most satisfactory playmates—a condition that portends trouble if not satisfactorily adjusted.

Then there is the child who reflects his mother's attitude, who refuses to fight or to be the aggressor and in consequence earns the name of "sissy," "Lizzie," and other epithets not conducive to the magnification of his ego. There is, too, the child who is the smallest of the group and whom the others habitually impose upon. He may be satisfied with the rôle for a time, but gradually the spirit of resentment is likely to creep in and the worm slowly turn. He may react to the situation in an asocial manner, often taking out his irritation on a still younger group or smaller brother or sister, if he has one.

Here, again, the problem resolves itself into one of education, and who is better fitted to cope with this situation than the worker, who has the opportunity of knowing these groups and observing the child in his original setting? Through the establishment of new interests and recreational outlets, she will often be able to displace the old sources of dissatisfaction and furnish new, constructive interests of a happier sort.

The third great source of dissatisfaction is to be found in the school life of the child.

He may be faced with failure in school through a lack of equipment. This problem has long been a well recognized field for social intervention; for the necessity of adjusting the feebleminded child is recognized much more readily than the vital importance of adjusting the child of normal or supernormal endowment who for one reason or another has embarked upon a career of misconduct. And yet in the one case we have a child who never will thrive satisfactorily except in a simplified environment, while in the other, that of the normal child, we permit a wanton waste of creative brain power by allowing that child to enter a career guided by destructive rather than constructive principles, if we fail to promote a satisfactory adjustment.

A further source of failure in school progress, with its concurrent dissatisfaction, is frequently loss of time through illness—for example, the long-continued diseases of chorea or organic conditions of the heart, etc. The child may realize that his failure to measure up to the other children is due to this, and to compensate for his sense of failure, he may enter upon a career of insubordination, such as playing hookey, etc., asocial manifestations from which he derives a sense of satisfaction.

And, finally, the child may fail to use his native equipment to the maximum either because of bad habits of study or of lack of interest on the part of teacher or parents. The interest of the worker may supply new stimulation and a new point of view through which the child may find that more satisfaction is to be gained by good school progress than by a refusal to meet his responsibilities in the matter of education.

To sum up, what shall we conceive as the broad aim of every social worker? She must first obtain a full knowledge of the principles of mental hygiene, out of which will come a broader understanding of human conduct. It is then her task to translate this understanding into influence. Through the medium of this new found influence, she must assist the parents to gain a broader view—to be open-minded, less bound down by tradition, more willing to let the child grow and develop in surroundings that do not tend to repress and confine him.

The social worker may likewise assist the teacher to recognize the problem of the growing child, to see that education fails when it is confined narrowly to physical and intellectual development, that each child must be given an opportunity to gain self-expression and to develop his own individuality instead of being turned out at the end of his school career stamped with the trademark of the general mold.

She should help the teacher to understand also the numerous pitfalls awaiting the growing adolescent child, tossed about on the restless tide of his emotions, that through this understanding the teacher herself may be enabled to furnish constructive help and guidance.

But the fundamental task of the social worker is that of helping the child with whom it is her privilege to work to a better understanding of himself and his relation to the family and his associates. In every case of misconduct she should conceive as her aim the careful examination of all the elements that enter into the case. Only upon the basis of such knowledge should she attempt the reconstruction of the child's environment, recognizing that no concrete rules can be laid down, but that each case requires a specific plan of action, fitted to its especial needs.

MENTAL HYGIENE AND THE COLLEGE STUDENT—TWENTY YEARS AFTER

ANONYMOUS

THE striking paper, *Mental Hygiene and the College Student,* read before the American Students' Health Association in Chicago last December and printed in the April number of MENTAL HYGIENE, may well arouse speculations in the minds of all college students and graduates in connection with the situation that the author describes.

The extent to which attention to mental hygiene is needed in our American colleges may perhaps best be understood by the study of what happens to college graduates who have had to get along without it. It occurred to me, a graduate of a generation ago, to go over the list of my classmates and see what might be gathered along these lines from my friendship with a few of them and my acquaintance with a larger number.

I found that about one-fourth of my classmates I knew practically nothing at all except such unenlightening facts as their residences and occupations and the dates of their marriages, deaths, etc., given in alumnal bulletins. So I confine my observations to the remaining three-fourths, of whom I know more, though in some instances scarcely more. Of these individuals I discover that about 40 per cent have, since graduation, shown signs of what I take to be neurotic, psychoneurotic, or even psychotic difficulties. Among this number are two-thirds of those who qualified for Phi Beta Kappa, and who, I might mention, include most of the most marked examples of mental and nervous diseases.

Of the deaths, which have occurred in 17 per cent of the class, I can only say that, so far as I know, all except two were from somatic diseases, though two-thirds of the deceased were among those classified as previously neurotic to some extent. One death was a suicide and another followed a strange coma that occurred a year after a serious operation, from which the patient never completely recovered, and immediately after a prolonged visitation from an uncongenial parent. After the chief physicians in the city where the patient lived had puzzled over this collapse for two weeks, and each had elaborated a different theory for it, their bewilderment was terminated by the patient's death.

Another type of casualty that it would be interesting to investigate, if one had the material, is the causes for the withdrawal of students who left college before completing their course, and their subsequent careers. I make out vaguely that the most brilliant of these temporary members of my own class was a very abnormal individual who suffered later from a psychosis and is now dead.

Taking up the 75 per cent of my class regarding whom I know more or less—generally less, but enough, perhaps, for the purposes of a scratch diagnosis—and considering the 40 per cent of these whom I have designated as representing various sorts and degrees of nervous and mental disorders, I will give a few brief summaries of the types of difficulties from which they appeared to suffer.

A—One of the ablest members of the class, who received not only the highest marks for scholarship, but also the highest office in the gift of the student body. This individual, an only child of New England extraction, was, it appeared later, of a markedly, though long latent, manic-depressive constitution, and after achieving considerable success in a professional field, succumbed some fifteen years after graduation to this increasingly emerging and menacing type of disease. A long course of psychoanalysis resulted in marked improvement and the diminution of the frequency and severity of the alternations of the emotional states, but the prognosis has never been considered very favorable by the psychiatrist in charge of the case.

B—Perhaps the most brilliant member of the class, who subsequently attained to the rank of a college professor. The patient's career in two colleges was terminated by the onset of depressions, the first mild and lasting for only about six months, the second severe and involving two years of treatment in hospitals for nervous and mental diseases. Since the latest episode a few years ago, the uncongenial profession of teaching, in which success was attained at such immense cost of vitality, has been succeeded by research work, for which this individual is eminently adapted.

C—An able student of the conscientious and thorough type, though personally very witty and original, this individual's painstaking and laborious methods of work having been clearly a compensation for felt tendencies toward indolence and dilettanteism. This was another only child of long New England ancestry. The tendency to a homosexuality somewhat above the average shown in undergraduate days developed later into what might be called a monogamic type of this character—one friend at a time and that practically for life. This is the patient whose last illness and death were so puzzling to the doctors.

D—The youngest member of the class and one of the most brilliant both in college and later. My earliest memory of this infant prodigy is of being awakened in the middle of the night in freshman year by the sudden sound of piercing shrieks and the tramp of the night watchman conveying the patient to the college infirmary. It transpired the following day that our young classmate had had "some kind of a fit." After performing able and devoted service in the foreign-missionary field, interrupted by several psychotic episodes, this patient came to an early death through a physical ailment.

E and *F*—Two very average students and ordinary personalities who were diagnosed by their fellow students as "darn' fools." Equipped with the compensating egotism of the true psychopath, they both embraced learned professions for which they had no natural endowment and in which they ignominiously failed. One is dead, and the other now occupies an insignificant clerical position.

G—One of the rather numerous neurotics, a good student and valuable member of society in subsequent years, of a rather narcisstic trend and somewhat markedly without heterosexual interest. This individual has had attacks of "nervous prostration" and has had recourse to sanitariums, with apparently good results.

H—An ordinary student and rather attractive personality, somewhat homosexual in college, who later contracted a marriage with an individual of another generation, and who has met the difficulties arising from this situation in what would appear to be an hysterical way.

I—A moderately good student and agreeable personality, inclined to be a bit "wild" in college, who had a distinctly psychoneurotic episode during the period of college life and was obliged to remain away for a year. This student married soon after graduation and very soon died of a somatic ailment. The family history showed several cousins, and later the patient's only sister, in institutions, "hopelessly insane."

The question that most naturally suggests itself is to what extent these morbid trends would have been distinguishable during the college years and how much could have been done at that time to counteract them. It is, of course, difficult to answer these questions with any fulness after the passage of a generation since graduation. A few incidents that occur to the memory, however, may indicate that in many of these cases an inkling of the real facts might have been gained by an intelligent mental-hygienist on the spot at the time.

I remember that one of the freshman themes in a class in English composition was *Memories of Childhood,* from which a considerably enlightening mass of evidence might have been adduced by an investigator. One of the themes considered good enough to be read aloud to the class by the instructor and later published in the college magazine was, I remember, the composition of the student *A,* and in connection with this the instructor was moved to remark that a better title would be *Confessions of a Morbid Child. B* came of a distinguished and somewhat neurotic family and was rather "high-strung." *C* was abnormally reserved, mature, and indifferent to the lighter side of college life. *D* clearly might have been identified by the "kind of a fit" that landed this precocious youngster in the infirmary. *E* and *F* were clearly recognized as what they were, though at that time the word psychopath in its modern connotation was not even in the medical vocabulary. *G, H,* and *I* were all "different" enough in their various ways to attract even then the notice of a competent observer. The single suicide I did not personally know well enough in college to comment upon now, except to remark that this student was distinguished chiefly by being "rather gay" and thereafter by being among the first to marry. As the disaster occurred within a few years after graduation, there was probably something beginning to go wrong much before that.

There seems to be no reason to think that the ratio of neurotics exhibited by this particular class is unusually large. The class had the reputation of being rather more commonplace than its contemporaries, and if commonplaceness spells normality, it might pass for a good example of the average. It is sufficiently clear to one who has any intimate acquaintance with the individuals of this class that many of the catastrophies in later life were closely connected with and occasioned by mistakes in the choice of an occupation, even if the more fundamental causes were other and more obscure, and that perhaps many of the most serious breakdowns might have been prevented if there had been more intelligent guidance in the selection of vocations to be followed after graduation.

If, indeed, so large a proportion of mental difficulties and disasters attend the subsequent careers of the members of the ordinary college class, this high liability to accident would seem to deserve attention and to emphasize in no uncertain terms the importance of a systematic mental hygiene for college students.

MENTAL HYGIENE PROBLEMS OF NORMAL ADOLESCENCE*

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"NORMAL ADOLESCENCE" is a combination of terms that may perhaps be considered contradictory. If by normal one means average, and at the same time implies painless adolescence or adolescence without conflict, then certainly there is a contradiction. For the adolescence that occurs without stress and strain is too unusual to be called normal, and if it were the usual thing, it would have no mental-hygiene problems to be discussed. What we must mean, therefore, is the mental-hygiene problems that arise in practically all ordinary lives at adolescence, disregarding those extremes of maladjustment which seem to point toward serious mental breakdown.

If one thinks of human life as the continuous struggle of a segmental organism so to organize its various needs and interests with relation to a social and physical environment that it goes forward successfully—satisfying itself and winning social approval at the same time; striking a balance between a dynamic safety attained by courageous, intelligent action and a static safety that means regression and avoidance of action; substituting, as far as intelligence permits, expression for repression, independence for dependence, objective for subjective, and concrete interests for dreams—then adolescence inevitably presents a crisis, a possible turning-point, a place where the struggle must necessarily be more aggressive and effortful if it is to result advantageously for the organism.

The ideal of adjustment that mental hygiene holds before us might be stated in this way: The organism is able so to coördinate its own cravings that they can be expressed satisfactorily and objectively in socially approved ways. This implies that organisms use their intellects or intelligences in meeting the facts of every situation squarely, and work out their satisfactions in terms of those facts. They use no indirect, evasive, or subjective means to escape the problem of wrestling biological success from the world of men and things as they actually are. In other words, the healthy adjustment is the scientific adjustment, which controls situations by mastering the facts in the case and manipulating them with intelligence and skill to carry out the ends of the individual. It is never to be forgotten that the most important situations which the human being has to meet are social, and that the facts he has to understand and work with for the solution of his problems are social, too. The way human organisms behave is as important for him as the reactions of the physical environment. There is no moral reason why the organism may not use any control it can work out, but, as a matter of fact, no thoroughgoing control can be attained on any other than a realistic basis. All other methods are subjective and illusory and break under the strain of living. If the mental-hygiene goal for human beings is biological fulfilment, success, objective expression of the great human interests, independence—in short, full-grown adult individuals who face life in a positive, aggressive, constructive way—then we must examine adolescence to see wherein it presents peculiar and unusual obstacles to all young people in the attainment of such an ideal. Why should life become more difficult at that point and hold so many possibilities of disaster?

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* Read before the Mental Hygiene Section of the National Conference of Social Work, Milwaukee, June 23, 1921. Reprinted by courtesy of the *Annals of the American Academy of Political and Social Science.*

Adolescence seems to be a crucial point which tests out the wholesomeness of the previous development. It is the point at which the individual takes on two selves. To adults around him, he is still a child when they wish him to conform to their desires; when he fails to accept authority and brings down condemnation for his behavior, he is reproached by the adult in terms of his age and approaching manhood. "Jimmie is almost a man. Doesn't he know a man doesn't do so and so?" But when Jimmie asserts his independence, he is quickly returned to the unfree state of childhood. Inside of Jimmie a similar conflict rages. At times he feels himself a free, independent individual who can go forth courageously into the world, leaving the oppressive weight of family authority and interference far behind him. But there are moments when he seems so helpless and alone in an uncharted country that nothing short of his mother's reassuring presence brings any relief. Whether Jimmie will be able to keep his face turned steadily, frankly, courageously toward the world of independence and responsibility, and slowly, but surely deprive himself of the comfortable protection of the family and maternal solicitude, depends upon everything that has gone into the making of Jimmie up to this point.

There are two lines of inquiry we should have to make to determine what Jimmie's chances are and what his problems are likely to be—first, as to the development of his work or play life; second, as to the development of his love and sex life. We want to know whether Jimmie has carried both his work and love interests beyond the subjective, auto-erotic stage over into an objective fulfilment, as far as his ability and environment permitted.

First, on the work side. Is he occupied for the most part with realizing concretely his work, or, if you wish, his play interests? If he wants a wagon, will he cry or sulk or have a tantrum until his father gives in? Will he steal a wagon? Will he brood over it, dream about the wonderful things he could do with it, but make no effort to get it? Or will he apply himself energetically to some plan for earning the money or building a wagon of home-made materials? How difficult is it for Jimmie to put his desires into effective action? How difficult is it for him to get what he wants in terms of the facts as they are, without evasion, antisocial behavior, or substitution of daydream fulfilment? Moreover, one must ask how interested is Jimmie in work and play? Has he a plentiful supply of interests, and have most of these interests definite, concrete ways of getting expressed? That is, has Jimmie both the drives and the developed techniques for realizing them? Whether or not he has will depend not on Jimmie alone, but on the entire background to which Jimmie's behavior has been a response.

If Jimmie has been under a strongly repressive discipline; if all of his attempts have been discouraged or subject to ridicule; if environment has limited too greatly his opportunities; if health has prevented aggressive or effective action; if some inferiority, real or imagined, physical, mental, or social, has developed a habit of non-aggressiveness, a fear of attacking a new project, a hesitancy to go over into positive action, a tendency to evade responsibility because of fear of failure or exposure of weakness, then we may expect to find adolescence producing the most critical problems. A child who has grown up on the subjective plan, who has never learned to deal squarely with facts or to win approbation by legitimate efforts, or who has gone into compensatory activities of an antisocial or auto-erotic character, has been able to put off the results of such methods of meeting reality because of his childhood. The family, even the school or the foster family, will accept many such bad adjustments as a part of childhood without realizing how serious they are.

With adolescence, however, comes a point when life looms up, and even the family cannot continue to protect the child from his growing years. He must begin to get the come-back from his habits of poor adjustment. The patterns he has been using will not work in a world outside of family protection. If he has not been accustomed to finding active, concrete expression for his interests, the sudden flood of new energy, the widening of the horizon, the social impetus that youth receives, will swamp the motor apparatus. He has no techniques developed and has not the habit of trying to develop them for every new interest. These vague, but powerful forces coming in upon the old situation are difficult enough to harness into actual achievement, even with the best efforts of adolescence. They imply the subtle, elusive, complicated techniques of social relationships and community life, the creative expressions of art, with techniques that take a lifetime to master—the complicated processes of all the various enterprises of an adult world. They involve not only difficult techniques, but the willingness to free onesself from the economic support of the family and take on responsibility for one's own living. There is a tremendous fear to many young people in the thought of economic independence—no money to fall back on unless you are able to earn it. Supposing you should lose the job! No father, with open pocketbook, to help you out, no comfortable home to drop into when work gets unpleasant. When that realization is suddenly forced upon the adolescent, there is often real terror behind it, and it requires a genuinely healthy, courageous habit of meeting the problematic situations in life to adjust to it without evasion.

A very unstable girl of eighteen, who has been forced to work since she was fifteen because she has no family back of her, resists work and changes jobs frequently, but is obsessed by fear as soon as she is without work. She has contemplated prostitution, and has gone so far as to go with one or two men for the sake of an evening's entertainment.

But the fear she feels when she is not working is too great to allow her to depend on men friends completely, and she resists the loose living unless she has a good job. Her dislike of work, her fear of growing up, are so great that the necessity for working has been registered almost as a compulsion. Needless to say, she also fears adult sex life and is held back by that.

This particular girl, whom we will call Alice, illustrates the adolescent conflict when there is too great a pullback, too many obstacles in the way of normal growth. Her early home life turned her against men and sex because her father was an abusive drunkard, unable to support the family. Her mother put all of her love and desire into the indulging and spoiling of Alice. Alice was taught to dress above her station and to feel herself better than others. She was the petted, adored, only child. Then the mother died, leaving Alice to an unsympathetic, overworked old grandmother, whom Alice has never ceased to blame for her lost childhood and its pleasures. Alice submitted, but never accepted this change of living. She never ceased to long for the mother and the delights of adoration and dress and pleasure obtained without effort.

The grandmother died, leaving Alice without any one, penniless and with not even a common-school education. She goes to work without skill or training, hating the grandmother and even her mother for dying and leaving her to such a fate. She has never developed the kind of initiative and persistence that will enable her to get education by night work. She is not strong. She craves pleasure. She blames other people and fate for every misfortune. She develops an evasive way of meeting every unpleasantness, every failure of hers on a job. She is often late to work, she resents correction childishly, she is unreliable, stays away if she has the slightest pain, wants a lot of attention, has no idea of business etiquette. When she loses a job, the employer or a fellow employee is to blame.

Adolescence increases the yearnings for a home, for a mother to fall back on. The only other outlet she can see leads to the pleasures that mean sex—cabaret, movie, dance hall. Alice is afraid of sex. She resists the idea of marriage. What does she want with children? Look how her mother suffered and in the end had herself and a baby to support.

So Alice is caught with no developed interests, no techniques, nothing to stabilize or inhibit the regressive impulses. When one talks with her, one gets the full force of the adolescent yearnings. She wants to be somebody, to do great things, to be superior. In her good moods, she is overwhelmed with dreams of accomplishment. She pines to use good English, to be a real lady. There is pathos in her inquiry as to what you say when a boy introduces you to his mother and how to behave in a stylish hotel dining room. Such questions have an importance that is almost greater than the problem of how to keep straight sexually. Winning of social approval is an ever-present, burning desire, but she has no patterns, no habits, no control over the daily details of the process whereby this is gained. When one tries to place her in a good environment with girls of a better class, she reacts with a deepened sense of inferiority, expressed in more open, boastful wildness. She invents adventures with men to dazzle these virtuous, superior maidens. The craving for pleasures and something to make her forget increases.

What one would do, if it were possible, is to hold Alice long enough to see her through the learning of some skill or technique in which she could be really superior and by which she could earn a decent living. The difficulty is that, owing to the amount of instability that has been developed, it requires almost constant supervision just to keep her in one place physically, as well as to hold her to the daily effort of mastering a hard task. It also takes a great deal of money, for which no guarantee of success can be held out.

It is not strange that youth finds it hard to buckle down to concrete accomplishment. The urge of life is so intense, the dreams so quick and glorious, the actual process so slow. Dorothy, a youngster who by temperament and every handicap of environment had learned to depend almost entirely upon daydream fulfilment, found herself at seventeen facing the problem of earning a living. She had not one single worked-out process to make her useful to any human being. She was unstable, imaginative, impatient, undeveloped to the *n*th degree. It looked like a hopeless proposition. All the authorities predicted ultimate breakdown and failure. One faithful person took her into her own home, provided a stable background, and concentrated all her efforts on holding the child to learning one technique by which she could become self-supporting. There were ups and downs—she ran away, she stayed out all night, she made living a stormy affair for her friends, she quarreled with every companion. She had to be held down to studying her lessons at night by the constant attention of an older person. Her course in stenography was interrupted by absences and bad behavior. In the end the worker on the case triumphed. The child completed the course and took a job. She had developed a genuine skill. Although her work record for a long time consisted of one job after another in rapid succession, the fact that she knew how to do one thing well always brought her back to working and its possibilities. The periods of keeping one job grew longer, the upsets less damaging to work. Friends held on. After three years, when some of the adolescent conflict had abated and the growing skill as stenographer had begun to have its effect, we find our unstable girl steadied down into a well paid, reliable worker, whose emotional upsets are understood and adjusted to by her without giving up work.

We have been following the development of the play and work interests of the individual and trying to show how a subjective, regressive development—or call it a lack of development, if you wish—leads to greatly heightened conflict at adolescence because of the increased pressure of internal as well as external forces.

On the side of the love interests, the development of social relationships which can be separated from the work side only arbitrarily, we find a similar situation. The individual whose love life and social interests have broadened progressively and have taken on a more and more objective character meets the effort required of adolescence to face adult sex and social responsibility with courage and positive striving. The individual who, because of some inferiority, real or imagined, physical or mental, has tended to depend upon mother love or family tolerance, and has avoided the possible criticism of an outside world by shutting himself away from others and comparison with them, will easily find in adult love and heterosexual relationships something too difficult to be faced. He will desire either to remain in the sheltered family situation, where he is loved no matter what he does or is and where as a child he can cling and depend and feel no responsibility for loving back again, or he will find in the world some one who will accept him on the same basis, and allow him to remain infantile or childish in his love needs.

Such a condition is, of course, often produced not by any essential weakness of the individual, but by a combination of circumstances—an infantile or unsatisfied father or mother using the child in a selfish way to appease his or her own love needs, preventing it from growing away from the parental attachment as it normally should; the widowhood of the mother forcing the boy to take the father's place and attaching his love for life; the handicap of a long physical illness or extreme delicacy reinforcing the ordinary resistance to going over from the certainty of mother love to the winning of heterosexual love under conditions of rivalry and possible defeat; the accident of circumstance which deprives the girl or boy of contact with the opposite sex at a time when the transfer of love interest is ready to be made and conditions him or her to homosexual or auto-erotic expression; the repression which puritanical adults, teachers, parents, schools, orphanages, put upon the normal heterosexual impulses of adolescence. When one contemplates all the influences that are at work to prevent the courageous, objective development of love and sex, one wonders why adolescence ever follows a normal biological course.

Alice illustrates almost all of these influences. She is held back from maturity by the pull of childish cravings for mother love and protection. What she wants is not the objective adult love of one independent individual for another, but subjective satisfaction. She is not looking for the kind of man whom she can love with a real appreciation of his qualities and a sharing of his interests; she is looking for any one who will give her the sense of security, the spoiling and indulgence, that the mother supplied. Alice seeks not a mate, but some one to devour. She will consume her love object. She is not motivated by any dreams of home and children. Her hunger is for a pleasureful, care-free existence in which she is responsible neither for work nor for love. Even on the physical side of sex, Alice has no desire for adult expression. She has all of the repressions which he mother's hatred of men, her father's behavior, and conventional sex taboos could produce. Theoretically, she is as prudish as any carefully guarded virtuous maiden, but her practice and her theory are as separate as the poles. Alice sins, but she refuses to embrace her sin. Physical sex is a disgusting fact of life to which she yields because it buys the pleasures that are essential. Her conflict is none the less real for its inconsistency.

What can we do practically to meet the complicated problems of adolescence? How can we lessen the struggle or lend strength to the forward-looking interests and impulses? If we wait until adolescence has begun, we shall have a difficult task. But granting that most of the adjustments should have been made earlier and taking adolescence as we actually find it, what is possible?

We can surround youth with encouragement. There need be no sneering superiority, no ridicule, no tyrannical authority, no dogmatic overruling, nothing to undermine the confidence and assertion that are necessary to approach work and love on an adult basis.

We can have young people as free as possible to develop their own interests, free to discover for themselves, to experiment, even to make mistakes. We can give them freedom to experiment in the ordering and control of their own group life as well as their individual interests.

We can recognize and supply the need of youth for interpretations of life, ethics, religions, philosophy, scientific and social theory — something general enough to be mastered verbally and used to reduce the chaos of a new world to a known and familiar thing; something to make life a safer, more manageable affair. Adolescence craves a unifying theory to use as a stepping-stone from the safe limits of childhood to a boundless universe, otherwise too strange to be faced.

Parents and schools can see to it that youth is supplied with definite skills and techniques, that potential interests go over into action. They can show young people how to gain an objective happiness in creative work. They can so equip adolescence that it will not be left defenseless in the face of an adult world, with only dreams to offer.

The family can reduce the pullback of childhood by encouraging economic independence, breaking away from home, going away to college, widening the social interests to extend beyond the family circle. The parents can keep their love for the child objective and unselfish and welcome his growing independence and heterosexual interests.

Last and most important, if we are wise enough and grown up enough ourselves, we can give the adolescent an interpretation of sex and human behavior that will enable him to face frankly his own cravings and inferiorities, real or imagined, and to adjust to them in a positive, constructive spirit.

Sex instruction as now provided in the public school is not equivalent to assisting youth to a happy emotional adjustment. Like Alice, one may know the facts of sex and hate them. Can we provide parents and teachers so well adjusted and understanding that they can take the adolescent at the critical moment and, through their own courageous and positive attitudes, show him the way? For he needs not only to face sex and learn to look forward to love and marriage; he needs even more to accept himself, honestly and frankly—to recognize inferiorities and abilities and learn the lesson of compensation.

I can leave you no better picture of adolescence and its cravings than this phantasy taken from the diary of Dorothy, the sixteen-year-old girl whose struggle to meet the realities of working life I described earlier in the paper:

"I am between heaven and earth. I float, as it were, on a dream cloud which carries me up at times into a glorious atmosphere and again nearer the mucky earth, but always on, always on. I see not man, I see not the children of man, the big Me lies in my head, in my hand, in my heart. I place myself upon the throne of Kings, and tramp the dusty road, care-free. I sing to myself and call me pretty names; I place myself upon the stage, and all mankind I call upon for applause, and applause roars to me as the thunder from the heavens. I reason that mine is not inevitable stage-madness which comes to all females of my pitiful age; mine is a predestined prophecy, mine is a holy design, my out-coming is a thing to be made way for.

"I bathe myself in perfumed waters, and my body becomes white and slender. I clothe myself in loosened gowns, silks as soft as thistledown, and I am transported to scenes of glory. The even stretch of green, bedecked with flowers to match the color of my pale gold gown, is mine to dance and skip upon. A lightness and a grace comes into my limbs. What joy is mine! I leap and spring and dart in rhythm with nature, and music leaps from my steps and movements and before my eyes are men. Men and women and children with heads bent forward, with eyes aglow with wonder, and with praise and love for this essence of grace and beauty which is I. What more, what more! I hang upon this idol of a dream, but it is gone. The height of happiness is reached; alas, even in dreams there is an end to happiness, the bubble bursts, and the dust and noise of earth come back to me. I shut my eyes and ears to these and seek consolation among the poor. In dreams I go often among them. With my heaping purse of gold, I give them clothes and beds to sleep upon, I give them food to nourish them and me, to nourish and refresh my fame. But do I give my gold away, and does my purse cave inwards? Ah, no! Come to my aid, my imagination, for thou art very real to me to-day. An endless store of gold is mine in banks of state. My name is headed on the lists of all, my money does increase even as I hand it to these poor. The poor bless me, they kneel and kiss my hands. I bid them rise, and the hypocrisy of my godless soul bids them pray and in this find restoration.

"I grow weary as I walk, and truth is even harder yet to bear than ever before. I am sad, I have nothing, I am no one. But I speak soothingly to myself, bidding me treat my hungry self to food, and I promise that the night shall be long and the dreams and journeys many."

SUICIDE IN MASSACHUSETTS

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AS one of the phenomena with which society has to deal permanently, voluntary, self-inflicted death or suicide has attracted the attention of philosophers and scientists of all ages. It has been inferred that suicide was very common in classical times, was comparatively rare during the Middle Ages, and has increased since. This increase, to which every writer on suicide calls attention, is easily demonstrable during the past hundred years, or since vital statistics have been kept. Wherever such statistics have been collected, an increasing suicide rate is found.[1] Much has been written on the subject, the best analysis, perhaps, having been made by Morselli,[2] who concludes as follows: "The certainty of the figures and the regularity of the progressive increase of suicide, from the time when statistics were first collected to now, is such and so great even in respect to countries different in race, religion, and number of inhabitants, that it is not possible to explain it otherwise than as an effect of that universal and complex influence to which we give the name of Civilization."

There is a universal belief that life is now more complex and that the struggle for existence is more difficult. If this is true, it is to be expected that more people should fail and resort to suicide. But what are the facts? No data are at hand and in so far as written opinions are concerned, each age has had its complexities and difficulties analogous to our own. The theater and the romance were lamented one hundred years ago, as are the dance and the movie to-day, and proof is lacking to show that the personal life of the individual is more hazardous than formerly. There is, however, some evidence of an hyperæsthetic condition, or increased sensitiveness to stress. This is the opposite of stoicism. Our demands are more, and what our ancestors took as a matter of course we regard as a hardship. In this sense the struggle has increased. It has been suggested, too, that the decline of the death rate may result in the survivors being less vigorous than formerly and so more susceptible to suicide.

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[1] This is well shown for American cities by Hoffman, who found that the peak was reached in 1915, with a rate of 21 per 100,000 population. See Suicide Record of 1919. *The Spectator*, December 2, 1920, pp. 11-15.

[2] See *Suicide: An Essay on Comparative Statistics*. By Henry Morselli. London: C. Kegan Paul and Company, 1881, p. 16.

With the idea of gaining some light upon the subject, the National Committee for Mental Hygiene engaged the writer to study a series of cases of suicide in Massachusetts, for the purpose of determining, if possible, their causes. As a background for such a study, it was necessary to investigate to some extent the whole subject of suicide in Massachusetts. This report, therefore, is in two parts—one dealing briefly with the general subject of suicide in Massachusetts and the other with the particular cases studied.

Part I

A study of the suicide rate in Massachusetts for the last seventy years shows that there has been an irregular, but certain increase.[1] In 1850, the rate was 4.9 per 100,000 living persons. (See Table I, page 758.) This reached 14.1 in 1893, 13.9 in 1908, and 13.9 again in 1915. Though the rate fell off a little during the war, as is usual, it is already ascending again, being now around 13. This means that there are about 500 deaths by suicide a year throughout the state. This does not include the certain percentage of unknown deaths that are surely suicidal, nor does it give any idea of the daily stream of attempts at suicide treated in the accident wards of our great hospitals.

How shall we explain this striking increase? What changes have taken place to bring it about? Are they individual or environmental? Statistical studies in other fields reveal changes in certain phases of life that may possibly have a bearing upon the suicide rate.

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[1] There is very satisfactory material for statistical analysis in this field, as registration reports contain data on suicide since 1841, and since 1885 a good deal of detail is to be found in the reports of medical examiners, who investigate every death by violence. This material has frequently been analysed, notably by Dewey. See Statistics of Suicide in New England. By Davis R. Dewey. *Publication of the American Statistical Association*, Vol. 3, pp. 158-175, June and September, 1892.

One of the most noticeable changes in the Massachusetts census reports has been the increase in the population of cities and the decrease of the percentage of the population living in rural communities. (See Table II, page 759.) Inasmuch as suicide is constantly greater in cities, and especially in large cities, this suffices to explain a considerable amount of the increase. In the year 1900, the rate for Boston was 13.7 and but 9.3 for the whole state. In 1905, the figures were, respectively, 14.4 and 9.9; in 1910, 15.4 and 13; and in 1915, 19.7 and 13.9. Hoffman[1] shows that in Berkshire County, with an increase in urban and a decrease in rural population, the suicide rate increased from 2.7 to 5.9 per 1,000 deaths. Whether there is something inherent in urban life that predisposes to suicide, or whether those individuals whose handicap leads to this act tend to accumulate in large cities, is a problem that offers a promising field for sociological research. However, the rate for the state is now higher than the old Boston rate, so other factors must be at work.

Another striking change in recent years has been an increase in the divorce rate. (See Table III, page 759.) In 1870 there were 26 divorces per 100,000 of the population; in 1917, the rate was 68.6. At the same time the marriage and birth rates have both gone down, and illegitimacy and homicide have increased. All these changes represent to some extent the effect of custom upon human conduct. Divorce represents escape from a disagreeable situation; but its increase would indicate a relaxation in social discipline that has favored it. So it may be with suicide. Anticipating, for a moment, some of the facts to appear later, it may be assumed that self-destruction is a more or less instinctive reaction to certain depressive states of mind, especially despair, which implies loss of hope. This is comparable to the blow in anger, and represents emotional expression. It is a means of escape always open, and so in the past church and state combined to check it by repressive measures. In studying cases, one can easily see why most of the individuals concerned committed suicide. A more perplexing question is, Why do not certain forlorn, sick, and friendless ones end it all? Undoubtedly the pressure of public opinion, as expressed by law and church restriction, has had a restraining influence. Suicides have actually been buried ignominously in the highway in Massachusetts,[1] and many have been refused the rites of the church. A hundred years ago, such sermons as *Suicide: An Atrocious Offence Against God and Man,*[2] and *The Guilt, Folly, and Sources of Suicide*[3] were thundered from the Protestant pulpit; now many clergymen secretly condone the act. From this it would appear that change of custom is represented by an increased suicide rate. Public-health measures framed to reduce this cause of death must, therefore, either restore the public opinion that acted as a check on suicide or find a substitute.

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[1] See Suicide and Modern Civilization. *The Arena*, Vol. 42, pp. 680-695, May, 1893.

Attempts have been made to show that the suicide rate varies according to an economic law. This has been done largely by the use of facts that may be related merely by coincidence. For instance, the highest suicide rate in Massachusetts was 14.1 in the panic year 1893, and the constant decline of suicides during wars has been attributed to the fact that every one had a job at high wages. To determine, if possible, the influence of economic factors upon the suicide rate, the writer made three comparisons of this rate in Massachusetts—with savings-bank deposits, with Gibson's Index of commodity prices, and with unemployment.

Savings-bank deposits have risen from $5.58 for each person of population in 1834 to $251.49 in 1915. A careful study of the annual rise and fall of the percentage of increase of savings-bank deposits and the suicide rate shows little if any correlation. For instance, in 1851 the deposits increased 9.79 per cent with a suicide rate of 5.6; the next year the per cent of increase of deposits was 12.5 and the suicide rate was 7.3. In 1893, we have a low deposit rate—2.06—and a high suicide rate—14.1; in 1894 deposits were 2.68 and suicides 9.2, but in 1895 both deposits and suicides increased, being 4.44 and 10.2 respectively.

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[1] See *A Glance at Suicide as Dealt with in the Colony and in the Province of the Massachusetts Bay.* By John Noble. Massachusetts Historical Society Proceedings, Set 2, Vol. 16, pp. 521-532, Boston, 1903.

[2] By Reverend George Henry Watkins. London: Cox and Son, 1818. 32 p.

[3] By Samuel Miller, D.D. New York: T. and J. Swords, 1805. 72 p.

Figures on the prices of commodities are available since 1890 in Gibson's Index. (See Table IV, page 759.) Again no correlation is shown. In 1890 the index number was 43.4 and suicide 8. The next year, 1891, the index number rose to 50.9, and suicide dropped to 7.4; in 1892 the index number fell to 45.3, and suicide rose to 10.2; and this lack of correlation continues.

The returns as to unemployment in Massachusetts have been made quarterly. (See Table V, page 760.) Both suicide and unemployment are seasonal, and the high point comes at opposite seasons, being in the winter for unemployment and in the summer for suicide. For the eleven years 1908 to 1918 inclusive, the mean annual percentage of unemployment was 8.76 and the suicide rate 13.21. In eight years unemployment was below the average and in three years above. Suicide was above the average in each of the three high years of unemployment and below the average in six out of eight low years. In the years 1912 and 1913, unemployment was 8.3 and 8.5 and suicide 13.7 and 13.6, so the failure to correlate was not marked. From this brief study there would appear to be a correlation between unemployment in general and suicide.

The relation between insanity and suicide will be discussed later in Part II, but it is noteworthy that during the period under discussion, Massachusetts has done more than almost any other community to alleviate the suffering of dependents, even to the point of tremendously expanding this group. During the six years 1913 to 1919, 2,936 suicides occurred in Massachusetts, and but 67 were in state institutions, though an average of 18,628 persons were under care.

Other factors on which data are available in Massachusetts are age, season, sex, and method. The curves for age correspond closely with those of other countries, with, perhaps, less child suicide. The maximum in females is younger and the increase has been evenly distributed. (See Table VI, page 760.) A good deal of reasoning concerning suicide has been based on curves showing total suicides in total population without regard to the actual number of people living at each age. Dewey[1] showed clearly that old age is a factor and that the rate increases with advancing years. In the state census of 1915 the number of survivors at each age is given, and except for the period under ten years, the suicide follows the death rate in its gradual increase with advancing years. This might well be expected, as so many of the personal reasons for suicide increase with advancing years, while the joys of living often decrease.

Much stress has been laid upon the seasonal rise and fall of the suicide rate. In Massachusetts, as elsewhere, late spring and early summer show the highest rates, the winter the lowest, if we take any considerable number of years. Yet in any given year any month may be high or low. Just when mathematical coincidence leaves off and statistical fact begins is not clear to the writer, and neither is the reason for this seasonal distribution. It has been suggested that there is something corresponding to hibernation, followed by a period of low vigor. It is interesting to compare the rates below the equator with this in mind,[2] both seasons and suicide curves being reversed. To a casual observer it would seem that January presented more hardship than June.

Males predominate, as is the rule, but there has been some modification of the ratio. (See Table VII, page 760.) In the period 1851 to 1855, females made up .419 of the total. This ratio was gradually lowered, reaching .223 for a period of 10 years from 1875 to 1885, but has since increased up to the present time, having been .418 for the period 1915 to 1918. The explanation of this difference in rate may well be the relative infrequency of violence on the part of the female, though the recent so-called "emancipation of the female" should hardly have been accompanied by an increase in the relative number of female suicides.

Finally, as to method, the most conspicuous difference in method in this country is the more frequent use of firearms, though the increase in the use of illuminating gas is also striking. This is especially noteworthy since suicide by this method is usually more deliberate than by any other and so has a larger intellectual element.

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[1] See note p. 753.

[2] Suicide in Australia: A Statistical Analysis of the Facts. By G. H. Knibbs. *Journal Royal Society, New South Wales*, Vol. 45, pp. 225-246, 1911.

An analysis of methods used in Massachusetts during the three years, 1916, 1917, and 1918, is as follows:

Method	Male	Female	Total
Firearms	326	37	363
Gas	215	137	352
Hanging	162	50	212
Poison	100	86	186
Drowning	78	67	145
Cutting or piercing	97	13	110
Jumping	21	20	41
Crushing	16	6	22
Others	6	2	8
	1,021	418	1,439

TABLE I. Suicide Rate per 100,000 of General Population in Massachusetts, 1850–1920

YEAR	Rate	YEAR	Rate	YEAR	Rate	YEAR	Rate
1850	4.9	1868	6.3	1886	7.5	1904	10.2
1851	5.6	1869	6.5	1887	8.0	1905	9.9
1852	7.3	1870	6.3	1888	7.8	1906	9.3
1853	6.3	1871	8.2	1889	8.0	1907	12.6
1854	7.4	1872	7.7	1890	8.0	1908	13.9
1855	8.0	1873	7.5	1891	7.4	1909	13.1
1856	8.9	1874	7.2	1892	10.2	1910	13.0
1857	8.3	1875	9.6	1893	14.1	1911	13.1
1858	6.9	1876	7.2	1894	9.2	1912	13.7
1859	6.9	1877	9.6	1895	10.2	1913	13.6
1860	9.2	1878	10.8	1896	10.3	1914	13.6
1861	7.4	1879	9.2	1897	8.7	1915	13.9
1862	7.4	1880	7.5	1898	10.1	1916	12.1
1863	5.4	1881	9.1	1899	9.8	1917	12.8
1864	5.2	1882	8.7	1900	9.3	1918	12.6
1865	6.2	1883	8.9	1901	11.0	1919	
1866	5.6	1884	9.6	1902	8.9	1920	
1867	5.6	1885	9.1	1903	10.7		

TABLE II. Population of Massachusetts at Each Census, by Groups Showing the Increasing Concentration in Places of 5,000 and 25,000, 1875–1920

YEAR	UNDER 5,000		5,000 OR MORE		UNDER 25,000		25,000 OR MORE	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
1875......	542,368	32.8	1,109,544	67.2	967,388	58.6	684,524	41.4
1880......	551,841	30.9	1,231,244	69.1	1,035,677	58.1	747,408	41.9
1885......	528,849	27.2	1,413,292	72.8	1,035,362	53.3	906,779	46.7
1890......	513,807	22.9	1,725,136	77.1	1,083,743	48.4	1,155,200	51.6
1895......	465,662	18.6	2,034,521	81.4	1,067,326	42.7	1,432,857	57.3
1900......	443,764	15.8	2,361,582	84.2	1,168,182	41.6	1,637,164	58.4
1905......	428,871	14.3	2,574,809	85.7	1,134,007	37.8	1,869,673	62.2
1910......	417,205	12.4	2,949,211	87.6	1,210,934	36.0	2,155,482	64.0
1915......	393,102	10.6	3,300,208	89.4	1,269,643	34.4	2,423,667	65.6
1920......	386,967	10.0	3,465,389	90.0	1,302,390	33.8	2,549,966	66.2

TABLE III. Divorces per 100,000 of General Population in Massachusetts, 1870–1918

Year	Number	Rate per 100,000	Year	Number	Rate per 100,000
1870	379	26.0	1905	1,554	51.7
1875	577	34.9	1910	1,929	57.3
1880	580	32.5	1915	2,252	61.0
1885	645	33.2	1916	2,301	60.9
1890	654	29.2	1917	2,635	68.6
1895	954	38.2	1918	2,351	60.2
1900	1,258	44.8			

TABLE IV. Gibson's Yearly Index Numbers of Prices of 22 Articles of Food, 1890–1921

YEAR	Index number	YEAR	Index number	YEAR	Index number
1890	43.4	1901	44.5	1912	62.6
1891	50.9	1902	53.5	1913	58.1
1892	45.3	1903	49.0	1914	60.8
1893	46.0	1904	48.3	1915	64.0
1894	43.4	1905	47.2	1916	74.9
1895	42.0	1906	49.8	1917	110.8
1896	34.0	1907	50.9	1918	122.8
1897	37.7	1908	54.2	1919	121.4
1898	38.7	1909	59.2	1920	127.0
1899	41.6	1910	59.3	1921 3 mo.	80.3
1900	44.2	1911	56.9		

TABLE V. Unemployment in Massachusetts, 1908–1918

YEAR	Per cent of unemployment	Suicide rate	YEAR	Per cent of unemployment	Suicide rate
1908	14.2	13.9	1914	13.0	13.6
1909	8.0	13.1	1915	10.7	13.9
1910	7.5	13.0	1916	4.8	12.1
1911	8.1	13.1	1917	7.2	12.8
1912	8.3	13.7	1918	6.1	12.6
1913	8.5	13.6	Average rate	8.76	13.21

TABLE VI. Death and Suicide Rates in the Several Age Groups in Massachusetts, 1915

AGE	Population	Deaths	Suicides	Death rate per 100,000	Suicide rate per 100,000
1–9	699,152	13,917	0	1,990.5	0
10–19	617,293	1,632	14	264.4	2.3
20–29	705,348	3,234	99	458.5	14.0
30–39	588,946	3,823	90	649.1	15.0
40–49	470,446	4,825	103	1,025.6	21.8
50–59	317,447	6,058	102	1,908.3	32.1
60–69	180,975	7,323	64	4,046.4	35.3
70–79	87,399	7,613	24	8,710.6	27.4
80–89	23,235	3,988	8	17,168.0	34.4
90–99	2,071	654	3	31,578.9	*144.8
100+	46	25	0	54,326.0	0

*3 deaths in year. Usually 1 or 0 in this age group. Only 7 in 20 years, 1898–1918.

TABLE VII. Distribution of Sex Suicides in Massachusetts, 1851–1918

YEAR	Males	Females	No. of females to 100 males	YEAR	Males	Females	No. of females to 100 males
1851–1855	262	110	41.9	1891–1895	909	228	25.0
1856–1860	361	115	31.8	1896–1900	1,124	265	23.5
1861–1865	295	99	33.5	1901–1905	1,161	320	27.5
1866–1870	323	96	29.7	1906–1910	1,509	461	30.5
1871–1875	498	132	26.5	1911–1915	1,848	518	28.0
1876–1880	574	128	22.3	1916–1918	1,016	424	41.8
1881–1885	660	194	22.3				
1886–1890	651	182	27.9	Total	11,091	3,272	29.5

PART II

Much of the knowledge concerning suicide is based upon analysis of statistics and comparatively little upon case study. Medical contributions have for the most part dealt quite largely with suicide as a symptom of insanity, although the psychology of suicidal ideas has received considerable attention of late, especially from the Freudian school. Those having the most to do with suicide in this state—that is, medical examiners—have confined their study largely to the medical-legal aspects and especially the determination whether or not a crime has been committed.

For the purposes of this paper, the suicidal act may be considered as an emotional expression, seeming at times to be almost instinctive. It often appears to be a reaction to certain states of mind, corresponding to the blow in anger or to flight in fear, or any gesture. It may be conceived as a superlative in expressing the emotion of negative self-feeling. Just as the most extreme expression of rage is, "I'll kill you," so an analogous expression in grief is, "I wish I were dead." In fact, a great deal of the legal reasoning concerning homicide may be applied to suicide, and cases of self-destruction fall roughly into three groups, corresponding to the three degrees of murder.

In anger there is an impulse to strike. The blow may be directed at a door or a tree. The blow, and not its result, is the important thing to be considered. To be sure, certain cases involve premeditation, and the intellectual element seems important, but analysis reveals that in most cases at least emotion is dominating reason. So it is in the case of many suicides. This negative self-feeling leads to a distinctive turning upon self, the person wishing to kill himself rather than to die. In all the cases of suicide in which it was possible to gain an understanding of the emotional state of the individual, one thing was constant—viz., depression, often involving despair and the loss of all hope, the single exception to this being the type of case in which suicide was merely a complication of previous homicide, the joint act seeming to spring from rage based upon jealousy.

So two questions arise: (1) What factors in the career of the human being arouse those emotions that express themselves in suicide? and (2) What types of individuals, when depressive emotions are aroused, take their lives?

To anticipate a little, it would appear from our study that anything which may cause unhappiness may cause suicide; but it does not follow, necessarily, that any person will commit suicide if sufficiently unhappy; the individuals who do so seem to belong to a selected group.

As our group consisted of only 167 cases, the number is too small to warrant a statistical analysis; nor is this necessary in view of the fact that extensive statistical studies have been made by others. It may be worth while, however, to present a few facts not available in ordinary statistics, and to mention a few others for purposes of comparison.

Most writers, especially Morselli, give each race a definite place in the scale of liability to suicide. It is interesting to see that for the most part the same relative positions are maintained in our environment. One striking exception occurs, however—viz., the Irish born. Irish statistics on suicide place this race uniformly near the bottom of the scale, yet it will be seen by the following table (Table VIII) that they commit suicide out of proportion to their number in Massachusetts. It will also be noted in the table that the Germans have an excessive rate. Furthermore, previous studies in suicide have shown its relative frequency to be greater in the upper stations of life. Inasmuch as the foreign born in Massachusetts are frequently to be found in the lower social groups, it is remarkable that they should have contributed 44.4 per cent of the suicides, while forming only 31.2 per cent of the population.

TABLE VIII.

Per cent Distribution by Country of Birth of Foreign-born Inhabitants of Massachusetts and of Suicides among Them, 1915.

	Per cent of total foreign born	Per cent of suicides among foreign born		Per cent of total foreign born	Per cent of suicides among foreign born
Ireland.	18.2	20.0	New Brunswick. . . .	2.6	5.2
Canada.	12.0	5.2	Germany.	2.5	9.4
Russia.	10.7	9.4	Turkey (Armenia).	1.9	2.6
Italy.	10.6	6.7	Greece.	1.6	1.2
England.	8.3	16.2	Austria.	1.0	6.7
Poland.	7.2	1.2	France.	.5	1.2
Nova Scotia.	6.9	5.2	Switzerland.	.1	1.2
Sweden.	3.6	5.2			

An analysis of the character of residence of our series shows that 51 out of 160 whose residence was determined lived in a lodging or boarding house. This calls to mind a similar condition recurring in a series of 107 cases studied at the Massachusetts State Prison, 40 individuals of that series having been living in lodging houses.

No accurate census of the number of employed is available at the present time, but of our series but 62 were steadily employed at the time of their death; 36 were unemployed because they were unable to obtain work, 62 because of sickness or old age, and 7 for unknown causes.

The degree of education is given below, but unfortunately inferences cannot be drawn from this because of the large number whose education could not be determined and because of lack of data for comparison.

Education of Group Studied

Less than 8th grade	47
8th grade	39
High school	18
More than high school	7
Unknown	56
	167

Similarly we could not determine in more than 72 cases whether or not life insurance was carried, but of the 72, 44 had and 28 had not insurance. No clues were obtained in any case as to the relation between insurance and suicidal act.

No religious census of Massachusetts is available except that of the United States Census of 1916. According to this, about 71 per cent of those reported as church members were Catholics, but less than one-half the population were reported as members of any church. The Catholic religion is well known to have a low suicide rate in countries where this can be accurately studied, and while data for a final judgment are lacking, it would appear that the Catholic rate is somewhat higher in our series than would be expected.

Religion of Group Studied

Protestants	77
Catholics	54
Jewish	4
Unknown	32
	167

According to the census of 1915, 55.5 per cent of the adult population of Massachusetts are married. It will be seen that a considerably smaller percentage of our series had married, and that a considerable number had separated. The large number of widows and widowers of course is due to the relative old age of the group.

Marital State of Group Studied

Married	79
Single	45
Widower	19
Widow	11
Separated	8
Divorced	3
Unknown	2
	167

The relation between economic conditions and suicide has already been mentioned, and it is noteworthy in our series that 105 of the individuals were in perfectly comfortable circumstances. However, it should be noted also that economic stress is a relative thing, individuals who have nothing except a small weekly wage living contentedly, whereas the rich man who loses an appreciable fraction of his fortune is most unhappy. So in our series the economic factor seems to be a diminution of what the individual possessed rather than actual dependency.

Economic State of Group Studied

Comfortable	105
Marginal	28
Dependent	23
Unknown	11
	167

During the period beginning November 1, 1920, and ending April 1, 1921, there were reported in Massachusetts 167 deaths by suicide. These have been studied as far as possible, and form the basis of the study of individual causes. One of the first things noted was the infrequency with which a solitary cause operates. Even with those definitely insane, oftentimes some outward stress seems to precipitate suicide, while in those not insane usually several factors are involved. It is possible, in most cases, however, to say that the pressure to the act comes from within, as in insanity, or from without as in cases of extreme adversity. So our cases will be grouped in the following categories, as indicating the predominating features of the case rather than the single cause of the suicide.

Predominant Causes of Suicide in Group Studied

Mental disease (insanity)	65
Physical disease	25
Delinquency	15
Senility	9
Alcohol and drugs	9
Psychoneurosis	8
Abnormal personality	6
Domestic strife	3
Loss of employment	3
Death of spouse	3
Miscellaneous	7
Undetermined	14
	167

It will be seen from the above that mental disease or insanity is by far the greatest single factor in suicide, 65 persons, or 32.92 per cent, presenting symptoms indicating psychosis. This is in agreement with most modern writers, who usually estimate one-third of the cases of suicide as due to insanity. It is, of course, impossible to make a post-mortem mental examination, and aside from a few cases in which an adequate diagnosis had been made before death, judgment is based almost entirely upon an interpretation of the history as obtained from friends, relatives, and physicians. Of this group 28 appeared to have the depressed phase of manic-depressive insanity, 10 senile psychosis, 2 dementia praecox, 2 epilepsy, and 2 paresis, while in 21 cases it would seem futile to attempt classification.

MENTAL DISEASE

The following cases illustrate the general situation to be found in cases of insane suicide. In this group it will be seen that emotional depression is constant, but in addition the limitation of responsibility reduced the degree of inhibition exercised by the patient. Also, these are cases in which the depression is due to disease and is entirely auto-genetic.

Case 143: A woman born in England, married, aged forty-two, developed depressive ideas and mild delusions of persecution. She bought a revolver and attempted suicide, and was committed to a state hospital. After nine months she had improved so much that she was allowed to go home on a visit. Her symptoms continued in a mild form, and after two months she eluded her family and disappeared. A few days later her body was found in a nearby river. The hospital diagnosis was involutional melancholia.

Case 17: A woman of twenty-six, born in Poland, married, after a great deal of domestic strife was assaulted by her husband. He was sent to jail. She later developed auditory hallucinations or delusions of persecution and became violently excited. She attempted to kill herself on several occasions, once by strangling and once by stepping in front of a street car. She was committed to a state hospital, where, after a few days of mutism, she hung herself in her room. A diagnosis of catatonic dementia praecox was made.

Case 26: A man of thirty-five, married, born in the United States, who had a poor employment record, had for ten years been growing rather irritable and suspicious. About five years ago he lost a job and complained of persecution and stomach trouble. This increased until he was committed to a state hospital. There he was rather inactive and apathetic, but somewhat depressed over his stomach trouble. He was found hanging in the toilet one morning. Diagnosis: dementia praecox, hebephrenic.

Case 79: A man of fifty-two and a half, born in Ireland, single, had delusions of persecution, with some depression, for about a year. He was committed to a state hospital, but was released for a visit, as his family seemed able to care for him. One Sunday morning he went to his room to prepare for church. He was found later, having cut his throat with a razor. Hospital diagnosis: paranoid condition.

Case 102: A man, aged forty, born in Canada of French descent, developed depression and was committed to a state hospital, where a diagnosis of general paralysis was made. He was found hanging in his room, having left a note to his wife saying that he was going to kill himself because she had not visited him.

Case 131: A man of seventy-five, born in England, a widower, had a shock about five years ago resulting in a right hemiplegia. Since the shock he had been growing forgetful, complained of dizziness, had worried over money and his house, and for a month had been agitated and depressed, thinking that he was going to be turned out of the house. He was somewhat confused. He cut his throat with a razor. Diagnosis: organic dementia, depressed and delirious.

In these cases suicide should be regarded merely as a symptom of insanity. Though several of the cases cited have been in state hospitals, this gives no idea of the proportion of these cases that have received adequate medical care; the vast majority have never had a diagnosis of mental disease made. In certain instances individuals were recognized as insane by relatives and family physician, who were loth to send them to a state hospital because of the supposed stigma attached to commitment.

PHYSICAL DISEASE

The next group in importance is that in which physical disease, with resulting depression and loss of hope, seems to have been the important element. One frequently hears the term "institutionalization" used in characterizing the state of mind of the invalid. It will also be noted that these cases were all in advanced years.

Case 124: A woman of seventy-five, single, who had been a nurse all her life, became incapacitated through cardio-renal disease. She was in comfortable circumstances and receiving good care and showed no mental symptoms. She turned on the gas and was found dead in the morning.

Case 18: A woman of sixty-six and a half, a widow, in comfortable circumstances, had for years had violent attacks of ticdoloureux. She had been to many doctors without relief and at last had become a Christian Scientist. She turned on the gas while alone in the house.

Case 16: A man of seventy-six, married, with a happy family, had advanced cancer of the throat, which was extremely painful. He shot himself with a rifle.

Case 69: A man of sixty-seven who had been paralyzed and bedridden for twenty-five years was irritable and emotional and complained a great deal of pain. He shot himself in his bed with a revolver.

Case 147: A man of seventy-seven, married, had prostatic disease, with retention of urine, and complained of terrific pain. He wrote a note discussing his situation and shot himself.

Case 89: A widower of seventy-three, in comfortable circumstances, had arteriosclerosis, and one or two slight shocks. He lived with his son and daughter-in-law, with whom there was more or less friction. He turned on the gas on Thanksgiving Eve.

In all of the above cases, emotional depression had been present, as may be inferred from the suicidal act. Also some loss of intellectual vigor and emotional control may be inferred from advanced years. Yet there seemed to be actual adequate cause for depression.

DELINQUENCY

The next group in size is that in which the existing cause of suicide has been delinquency.

Case 19: A man of forty-nine, born in Massachusetts, had an illegitimate child by the housemaid. Upon going to bed one night, he suggested mutual suicide to his wife. She refused. He got up in the night and cut his throat.

Case 105: A man of forty-two, single, born in Armenia, had an illicit affair with another man's wife. The husband returned and shot the offender, but did not kill him. He was subsequently taken to jail, where he cut his throat.

Case 13: A man of forty-one, married, with a good position, swindled his employees out of a considerable sum of money, and on the eve of discovery drank carbolic acid.

Case 121: A single man of fifty-six, under arrest and awaiting trial for sexual assault upon children, shot himself.

Case 118: A woman of twenty-eight, born in Italy, whose husband discovered an irregular sex life with another man, confessed the truth to her husband, but got up in the night and shot herself.

Case 56: A woman of thirty-seven, said to have been somewhat nervous, wrote a letter to her husband in which she stated that she loved another man and could not live without him, so turned on the gas.

It is generally stated in such cases that fear of punishment is the underlying cause of the suicide, but closer analysis reveals that humiliation, remorse, and depression are the important factors. The habitual criminal or delinquent rarely kills himself, unless he be an extremely abnormal person. Comparatively moral people, whose transgression is exceptional in their lives, appear more apt to kill themselves.

WITH HOMICIDE

Four of this series of cases, of which the following two are examples, represent suicide as a complication of homicide.

Case 34: A man of thirty-five, born in England, who had married, but separated from his wife, became infatuated with a negro girl of twenty-two years. She rejected his attentions and complained of his annoyance. He met her on the street, told her of his love, and upon her rebuffing him, shot her and then himself.

Case 12: A man of fifty, born in Armenia, who had been divorced from his wife, came to her house to discuss alimony. Immediately upon entering, he shot her and his two sons, who came to her rescue, and then shot himself.

It is difficult to say whether these cases represent a person determined to kill himself and to take another with him, or whether the act is primarily homicide. Every case of homicide with suicide that has come to my attention has been that of a man enraged by jealousy, who has killed a woman and then shot himself; in my opinion, therefore, the suicidal act does not represent a discreet entity, but should be regarded as a complication of a particular type of homicide.

Advanced Age and Helplessness

Attention has already been called to the advanced age of the group in which physical disease was the most prominent factor. A number of cases, while not in excellent health, could not be said to be sick, and the outstanding feature in their case was advanced age and helplessness.

Case 26A: A man of eighty, who had lived alone for many years in his store and had prided himself on his excellent physical condition, shot himself during the night. He was a widower, and, while not dependent, was in danger of becoming so. He was a man much liked, but was always said to be on the "off side."

Case 13: A man of eighty-four, who had boarded for years in a family of friends, as he was a widower, and who was in comfortable circumstances, had complained somewhat of decreased vigor and was found dead from gas.

Alcohol and Drugs

The period of depression following an alcoholic spree seems to favor suicide.

Case 36: A married man of thirty-seven, after a protracted debauch in which he lost his job and his wife, was arrested and left in a cell in jail. He hung himself during the night.

Case 46: A man of fifty-eight, single, who had been a spree drinker all his life, saved up a substantial sum of money and went on a spree. He was intoxicated most of the time for a few weeks, and had spent all his money, so that he had to borrow from the landlady. He could not sleep or eat, and turned on the gas.

PSYCHONEUROSIS

It is ordinarily believed that psychoneurotics are not prone to self-destruction. When we consider the relative frequency of these conditions and the extreme emotional excitement that they exhibit, the fact that but eight of our series were in this category would indicate that death from suicide is relatively infrequent among them, though suicidal attempts are common.

Case 120: A single man of forty-three, a college graduate, had been neurotic and unstable all his life. He was a musician by profession, but had developed a tremor of his hands that prevented his working. While undergoing a course of psychoanalytical treatments, he took a dose of strychnia, which resulted in death.

Case 146: A man of twenty-nine, who had separated from his wife the year before and had recently been discharged from the army, complained of a sore mouth. He had been to many doctors, who found no organic basis for his complaint and diagnosed the condition as a psychoneurosis. He told his mother that he could stand the discomfort no longer and, going to his bedroom, took 40 grains of strychnia.

Case 57: A married woman of thirty-one had complained of various ills for many years, and had consulted many doctors. She had taken considerable veronal, and one day, while on her way home on a ferryboat, took a large dose of veronal, from which she died.

It will be seen that in the above group there was an underlying element of unstable personality, as well as symptoms of psychoneurosis.

ABNORMAL PERSONALITY

The following group is very similar and yet lacks active symptoms of psychoneurosis and represents the excessive reaction of a peculiar personality to rather inadequate stimulus.

Case 43: A single woman of forty-three, who had been a deaf mute all her life, without occupation or interests, had complained a good deal of lonesomeness, and had some financial stress. She hung herself.

Case 3: A man of thirty-nine and a half was talented and successful, but moody and erratic. He read such literature as *Why Worry* and *Memory Helps,* and had some friction with his wife. Without any noticeable change as a warning, he was found dead from gas.

Case 14: A man of sixty-five had spent his life trying to get rich by making some great invention. He was considered odd and frequently left his family without explanation. Upon finishing one piece of work and while without occupation or funds, he hired a room at a lodging house and turned on the gas.

Case 77: A single woman of forty-five, who lived alone and was considered rather eccentric and unhappy, formed an attachment for a young man who boarded in the same house. Upon his going away and apparently rejecting her, she turned on the gas.

Case 26B: A man of twenty-one, married, born in Italy, who had been in prison a good deal of the time since childhood, was returned on another sentence. His wife wrote him a letter saying that she was through with him; whereupon he drank sulpho-napthol and killed himself. He had made repeated attempts at suicide and had been diagnosed as a case of constitutional inferiority.

Case 26C: A man of twenty-one, single, who had complained of ill health and had worried over the future, but presented no symptoms of mental disease, left a note saying that he had done exactly as his brother had done the year before. Search was made and it was found that he had tied himself to a tree and then shot himself, so that he would fall in the river, repeating the act exactly as had his brother one year before. This case illustrates the possibility of suggestion as a factor in suicide.

DEATH OF SPOUSE

Cases immediately following death of spouse seem to be particularly deliberate, and the victims unusually free from abnormal mental symptoms.

Case 128: A man of fifty-two, in comfortable circumstances, attended his wife's funeral and dined with his family. After dinner, he stepped into the bathroom and shot himself.

Case 112: A woman of fifty-one, who had lived comfortably with her husband for many years, had but $300.00 in possessions at his death. She wrote a note explaining her act, and turned on the gas.

UNEMPLOYMENT

Whereas unemployment or loss of a job seems to have been an indirect factor in many cases, in no case could it be said to be the sole cause.

Case 83: A married man of fifty-eight years had been a successful salesman for many years. He changed firms and did not make good at the new work, so that he was left without a job. He was very anxious as to the future and seemed to grow old suddenly and finally shot himself.

Case 60: A widower, fifty-nine, had been a hackman all his life, but developed hernia, so that he had to change his work. He found difficulty in getting a job and was in financial distress. He went to a boarding house and shot himself.

While none of this series show suicide as an immediate reaction to the loss of a job, a number of cases have come to my attention, not included among these, where suicide seemed to be reaction purely to grief over the loss of a position.

DOMESTIC STRIFE

Quarrel with a loved one, though it occasionally arouses rage, if the element of jealousy is present, in every case arouses extreme sorrow.

Case 97: A man of thirty-three, who had been married but a short while, had friction with his wife. He left her for a time and then returned and tried to affect a reconciliation. She refused; whereupon he returned home and shot himself.

MISCELLANEOUS

Finally comes the miscellaneous group, the size of which is limited only by the number of cases in any series; but the general characteristic of the seven cases in this series seems to be reaction to an overwhelming sorrow.

Case 99: A man of fifty-two, born in Russia, Hebrew, had worked for many years and recently put his savings into a small store. Business was poor. He lost $1,000.00, and turned on the gas.

Case 93: A man of fifty-two, born in Poland, and happily married. His son-in-law had been very ill, at death's door. Then, as he seemed about to recover, he died suddenly. After a week of extreme grief, the father-in-law hung himself in the cellar.

Case 32: A watchman of forty, born in Austria, hung himself to a tree the night after his house had burned and his daughter killed in the fire.

Case 94: A woman of twenty-seven, married, born in Italy, visited a hospital, where her two children were very ill. That night she got up from bed and jumped from the window.

Child Suicide

Much attention has been attracted of late to the question of child suicide, all being called children who are under twenty-one. There were seven such cases in our series.

Case 11: A girl fifteen years, eleven months old had influenza two years ago, since which she has been seclusive, depressed, and frequently talked of suicide. Had been morose and sulky, staying by herself in her bedroom. Shortly after being called to breakfast one morning, she shot herself in the abdomen, dying later. The history of this case would seem to justify a diagnosis of dementia praecox.

Case 20: A boy of sixteen years and sixteen days, with eccentric parents, was a student in high school. The first year he had received poor marks; the second year he had failed in English, Latin, and French, but had been extremely good in military drill. He had been conditioned in his third year, and was approaching mid-year exams. He was described as "solitary and seclusive," "dreamy and listless," "reticent and diffident." He worried over his studies, frequently going to the teacher and asking for his marks. His parents were very strict. One Saturday afternoon, he went to an empty house and hung himself. There was a rumor that he had been forbidden to go to a ball game, but this was denied by his parents.

Case 29: A boy of seventeen years and ten months, born in Massachusetts, of French ancestry, a devout Catholic, had completed the sixth grade in school. Was said to have been a bright boy, and to have exhibited no abnormal behavior. He had been somewhat upset by the death of his sister one year before. He had done no work for two months, over which he had expressed some concern. He went to a dance with a girl friend, where his conduct seemed to be normal. Returning home at midnight, he undressed, put on his dead sister's black silk stockings, a one-piece black bathing suit, and khaki knickerbocker trousers, and wrapped his sister's skirt about his chest. Thus clad, he hung himself to the bedpost.

Case 47: A boy of sixteen, an orphan, with an excellent foster home, was in his second year in a preparatory school. He was slow in his studies. He had to repeat Latin the year before and to be tutored in algebra. His foster parents were ambitious to have him go to college. He was described as "a very sad boy," "easily discouraged," "no backbone," "shy and quite different." He had a deformity of his lower jaw, which made his speech hard to understand, and also caused difficulty in chewing his food. He had a plate made for his mouth the day before his death. Other boys ridiculed him because of his deformity. While returning from school one day, he alighted from a subway train and jumped in front of the next one.

Case 86: A boy of fifteen, born in Massachusetts of Irish parentage, a Roman Catholic, was an orphan, but had a good home with his paternal aunt. His sister is said to be hysterical. He was in his third year in high school, but for two years had been promoted with conditions. He had been warned four days before his death by a note that he must do better work in school or fail. Vision and hearing were defective, and he was clumsy and awkward physically. He went to school one forenoon and returned home at noon, going to the cellar to do some chores. He was found later hanging by a belt strap.

Case 132: A boy of sixteen and a half years, born in Russia of Hebrew parentage, had come to the United States at five years of age. He was in his fourth year at high school.

He was described as exceedingly bright, had done four years in three, and was on the honor roll. He was said to have been "quite unexpressive," "did not mix with other boys," and "did not talk at all." He was very cross to his family, quarreling with his other brothers and sister. He was very industrious, working assiduously in his father's store. He had been somewhat nervous for a year, and very fastidious about his food. One Sunday he had spent the whole day in the store cleaning it up. He ate no supper, but sat reading a story book. His brother said, "Why don't you study?" He replied: "That's my business." He was left alone at 10.30, when his parents retired. At 5.30 in the morning he was found in a bath tub half full of water, with the gas turned on.

Case 156: A girl of sixteen and a half years, born in Massachusetts, of Italian parentage, a Roman Catholic, worked in a paper factory. She was described as one of the best girls in the factory. She had mixed up a dose of Paris green the year before, following a suicidal threat. She had a sweetheart, with whom she went to church every day during Holy Week. He was planning to go away, and she feared that he would desert her. On Easter he had asked her to wait dinner for him, and she had not done so. Upon his arrival, he was angry, and she went to the cellar for fruit and while there drank Paris green. She was taken to a hospital, where she said that she did not want to die, and that she was extremely sorry, but she subsequently died. There was no evidence of pregnancy.

SUMMARY

The results of our study lead to the following conclusions:

1. The suicide rate has constantly increased in Massachusetts since 1841, when records were begun.

2. This increase represents the change in the attitude of the public toward suicide; whereas, formerly, an attempt to take one's life was considered sacreligious, or at least cowardly, and the church and public sentiment stood strongly against such conduct, to-day there would seem to be little public sentiment against suicide, and religious groups are more inclined to condone than to condemn.

3. Suicide may be regarded as an expression of emotion

of negative self-feeling, and so can be caused by any unpleasant experience. In this state the individual's desire is not to die physically, but to kill himself—that is, his personality. In his depressive frame of mind, the feeling against himself as an individual has become so deep that he would blot himself out. As in anger he may kick an inanimate object—this being the only gesture that for the moment will satisfy his emotion—although the end result, an injured foot, may be anything to his liking, so, at the depth of negative self-feeling, the blotting out of his hated personality is the only gesture adequate and this is accomplished, but at a price.

4. Individuals who commit suicide form a selected group, one-third of whom are frankly insane, while most of the others show some limitation of responsibility.

5. If suicide is to be prevented, three suggestions may be made: (a) that there be more widespread recognition of the importance of depressive states of mind; (b) that the psychological problems involved in depressive states of mind be dealt with on a psychological basis, the physician whose advice may be sought endeavoring to understand and to meet the psychological problems, both conscious and unconscious, that may be the source of the negative self-feeling rather than attempting to treat symptoms through "good cheer," homily, and platitude; (c) that further consideration be given to the question whether the present general sentiment, that suicide is justifiable or commendable, is desirable.

THE FUNCTION OF THE CORRECTIONAL INSTITUTION*

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THE term "maladjusted child" includes a great many and quite diverse problems. I shall confine myself to the consideration of institutions dealing with socially maladjusted children that are commonly grouped under the term of delinquent.

In Illinois, as in many other states, we have a number of institutions dealing with delinquent children. Two of these are maintained by the state—namely, the School for Delinquent Boys at St. Charles and the School for Delinquent Girls at Geneva. One very large school is maintained by the city of Chicago in coöperation with the Department of Education of Chicago and the county of Cook—namely, the Chicago and Cook County School for Boys. Then there are a number of detention homes throughout the state and private homes and other institutions, such as the House of the Good Shepherd for Girls and the Chicago Home for Girls.

All of these institutions are quite openly and specifically dedicated to the care of delinquent children. There are also, of course, a very large number of institutions, both private and public, throughout the state of Illinois which deal with so-called dependent children.

In the light of a recent investigation of several orphanages, a grave doubt arises as to whether such a distinction can be maintained or even whether it is wise to insist upon it. Dependency, feeblemindedness, and delinquency have so many points of contact, apparently, that it is more than likely that progress is seriously retarded by these very artificial distinctions whose justification seems to be based almost entirely upon sentimental rather than really practical grounds.

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* Read before the Mental Hygiene Section of the National Conference of Social Work, Milwaukee, June 27, 1921.

We cannot go into this problem further than to point out its existence. Naturally we are not advocating the lumping of these problems together and expecting one institution to care for all types. The question is merely suggested whether we are not facing here another step in the progress of public opinion such as marked the change of attitude toward the insane when the old asylum was given up for the modern state-hospital idea, and whether the next step in the institutional care of delinquents is not, therefore, a change in our idea of the nature of the problem and the proper methods of dealing with it in these institutions. Should we not develop a new name to indicate this change of view and to replace the term delinquent by one less censorious?

Whatever the facts may be elsewhere in this country, we are compelled by the truth to admit that in Illinois we do not regard the correctional institution with the same confidence, not to say respect, that we are accustomed to feel toward, let us say, a first-class surgical institution. This is not due to any shortcoming on the part of those who are officiating in these institutions, but rather to the peculiar line of development in the field of juvenile delinquency.

Informed students of this subject, whose first-hand recollections go back even a single generation in the work, have frequently remarked upon the apparent change that has come over the types of delinquents who are sent to institutions.

This change may be partly due to changes in the nature of the population—one of the most commonly urged explanations. Another possibility is that the observers themselves have changed and, having become older, look back upon the conditions prevailing in the days of their youth as better than at present, a reaction of conservatism that is not unusual.

On the other hand, it may be that these observations are well founded, and the explanation is that probation now takes care of those children who formerly would have been "cured" in the institutions, leaving only the more incorrigible ones for the correctional schools. As Judge Arnold, of the Juvenile Court of Chicago, once remarked in regard to St. Charles: "If Colonel Adams can reform these boys that I am now sending him, he is a wizard, because by the time the juvenile court gets through with a boy and decides to send him to a correctional school, it seems almost impossible that he can be changed by any ordinary human means."

That is undoubtedly the attitude that would be taken by the juvenile-court judge of any of our progressive courts.

The remarkable and far-reaching development of prevention and education that has resulted from the growth of the probation departments is unquestionably making itself felt in the institutional field. With the exception of a few of our less advanced communities, in the outlying districts of the state of Illinois, all the juvenile courts, especially the Juvenile Court of Chicago, are satisfactorily solving the problems of the great majority of cases that come up before them, so that they are not only "reforming" in the old sense all those cases that in bygone days would have redounded to the credit of the institutions as cures, but are actually sorting out for institutional commitment with ever-increasing accuracy only those cases which do not respond to educational and social treatment and which therefore are finally sent to an institution, not so much for what it is hoped to secure for them, but rather as a precautionary method of protection for the community. It is a last desperate hope, with the emphasis rather on the community's interest than on the child's.

It is no wonder, therefore, that our institutional staffs are not so sanguine about the beneficial effects of the institution as were those of a generation ago.

While all this may be important to a certain extent, it does not explain the main problem which crops out again and again in the study of delinquents, especially in institutions. That is, what is the difference between the delinquent child who is finally sent to an institution and the one who is successfully maintained on probation?

It is not the nature or the quality or the degree of his behavior difficulty, for every kind of delinquency that is represented by the institution population is found in larger proportions among successful parole cases.

It is not a difference in intelligence, for, in spite of certain evidence in support of that theory, further experience has not confirmed it. And, again, we know that for every feeble-minded person who has to be committed to an institution because of dangerous behavior, there are two or three, at least, of equally low-grade intelligence who are safely kept at work in the community.

Probably no characteristic distinguishes the institutional from the non-institutional case more frequently than that of temperamental insubordination. One might almost say that the child who is sent to a state correctional institution in the main goes there because, in addition to his behavior difficulties, he has exhausted the patience of the authorities, first in the home and the school and then in the court and on probation and finally in those institutions which act as buffers between the correctional schools and the community, such as the truant schools, the detention homes, and, in the case of Chicago, the Chicago and Cook County School for Boys, which receives boys for no longer than three months.

The only generalization that seems justified on the basis of these statements is that when it comes to dealing with the delinquent child, no generalization will hold. Each is an individual problem; a trite and oft repeated statement, indeed, and yet do we apply it in our organizations? The juvenile courts, which do their work almost entirely on the basis of the individual case, of course, have demonstrated and will demonstrate increasingly the fact that it is by individual study and individual treatment that results can be obtained, often astonishing results. But in our institutions there is little evidence of this. Even in those institutions glowing accounts of which have penetrated to us in Illinois, where the work of reclamation is said to go on at a remarkable rate, it would appear that this work is little more than a picking over of the junk pile for the uttermost remnant of reclaimable material. The final residue remains, in a large proportion, if not the major proportion, of the institutional group, unresponsive to the group methods, the generalizing discipline, and the repressive social atmosphere which, under the guise of military or other discipline, serves merely as a cloak for ignorance or incompetence on the part of the institutional staff.

It is not my purpose here to call names, and, as I stated before, I do not believe that the institutional staffs are to be held responsible for this state of affairs. But the community itself must accept the full responsibility so long as it continues to hoodwink itself by clinging to the long discredited methods of repressive discipline as a cure for behavior difficulties.

And why should an institution's efficiency be made dependent upon the number of "cures" that it can demonstrate in its annual report? Such cures, it is true, may be the ultimate objective, but unless somebody has at present a specific curative method, which will work with 100 per cent efficiency—or even 90 or 80 per cent or any major fraction—with the consequence that the institution has merely to carry out certain precepts to obtain results, why should we demand such cures of our institutional staffs, especially in view of the fact that they are dealing with cases in which the elaborate and highly skilled juvenile-court staffs have failed?

This is not a field in which any one person may claim to have the answer—neither the psychiatrist nor the psychologist, neither the sociologist nor the educator, neither the jurist nor the penologist. The answer is yet to be found. But are we doing anything to find it?

Where is the correctional institution in which the entire energies of the staff are bent upon utilizing these unreclaimed cases for the obtaining of facts upon which to base logical action?

What institution in this country, even among those in which research is being conducted, can say that the *major* object of the *entire* institution is to conduct such research—of which it is not the truth to say, rather, that research is *also* being done?

And, finally, even where the will is strong, where is the institution in which the staff is not so weak in intelligence, in education, or in special training as to be almost powerless to accomplish anything in this field?

It is very satisfactory and gratifying to know that certain individuals have achieved results with certain small and carefully selected groups of individual cases, and it may be interesting to learn that they believe their success was due to the fact that they used a certain amount of tact in their work or started out with the idea that these children were "at heart like any other children," or because they have themselves "a knack" or "charm" or "a strong personality" and so on. But what good does that do us, who are not gifted in this way, who are not able to select our cases, or who have not the climatic or other conditions which enabled a particular piece of work apparently to succeed? No facts have come out of these experiments beyond the fact that intelligence, refinement, and industry will achieve results in the field of juvenile delinquency, as elsewhere.

No one, to my knowledge, is in a position to say that by this and this rule can this selection be made, or that this or that quality indicates a favorable case or the reverse. It is all a matter of opinion, based largely upon personal prejudice or, if you do not like this term—to borrow a phrase from my friend, Mr. Albert Kales—upon "subliminal hunches."

When once the correctional schools change their attitude from that of more or less consciously assuming responsibility for achieving results in the nature of cures or corrections to that of experimenters, then may we hope that real progress will reward our labors. Then will the correctional school no longer assert pedantically that it is devised and equipped to change the delinquent into a well-behaved person, and more or less hypocritically hide its failures behind outward semblances of orderliness within the institution. Then will the courts, and perhaps the families of children with behavior difficulties, seek out the help of the correctional school as in acute disease they now seek the surgeon or physician. And the correctional school will no longer be the symbol of failure and of a forlorn hope, but will stand for knowledge upon which effective, purposeful, and intelligent treatment may be based; above all it will be the source of preventive measures which will still further reduce the number of cases requiring to be sent to such a school.

WHAT IS A "NERVOUS BREAKDOWN"?[*]

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AMONG the various avenues of approach that attract the scientific searcher after truth, there is hardly one that has so direct a bearing on the happiness and success of the individual life as that of modern psychiatry. And yet members of the medical profession, as well as laymen, are only just beginning to recognize something of the importance and breadth of this field of endeavor. It is the most neglected, and therefore the most misunderstood, part of that field that I wish to discuss.

What are the psychoneuroses?

What is a "nervous breakdown"?

Just what is meant by the word "nervous" when used as a description of a patient's condition?

I shall try to give a very brief answer to these questions in this paper.

Civilization was in the first place an expensive luxury. Like most luxuries, when indulged in for a time, it became one of the necessaries of life. The price of this necessary is continual conflict and eternal vigilance.

In the prehuman stage the fight begins in a blind, undirected way. It does not grow simpler as human reason is applied to the problem. Whether we start with Adam, just turned out of Paradise, or with an ordinary human infant, we see that the individual is constantly at war with his environment, trying to subdue it to his uses, trying to save himself from its power. We see that each step forward is made by some new victory over adverse forces, victory won only by tremendous and persistent effort. This is true of humanity as a whole, as well as of each member of the race. But for the individual the situation is immensely complicated. It is never a mere question of energy and clearly directed force. There are an endless number of uncertainties, of modifications, requiring a varied and continually changing equipment. It is evident that many a victory must go to the enemy.

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[*] Read before the Alumnae Association of the Woman's Medical College of Pennsylvania, Philadelphia, June 17, 1921, under the title, *A Modern Conception of the Psychoneuroses.*

And yet we know that the strain of the fight of humanity against the static forces of hostile nature has served on the whole only to raise the race to ever higher levels. The striving of man with man has at least sharpened his wits and helped develop his intellect. There is still another division of forces, the individual against society, but this, too, has a humanizing influence, tending to develop personality, and cannot be directly the cause of disease. We must go a step further, and here we may stop, for we can say that it is the struggle of the individual with himself that does the damage.

Human beings are made up of two naturally opposing streams of energy. The first goes back to the beginning of organic life, and consists of the instincts that have to do with the preservation and glorification of the individual life and those that continue and improve the life of the race. These two original types of instincts divide and subdivide and interlace with each other until only a few simple reflex acts can be said to have only one purpose in their working. Together they comprise all the wishes, desires, and strivings of the whole natural man.

The other stream of energy is made up of the civilization and the culture of the race and of the individual. For the person himself, this begins to operate as soon as the child is born. The instincts, being first in the field, can hold it against great pressure, and to a large extent they do so throughout infancy and childhood. Unless some outside limitation be imposed, the child does what he feels like doing, and when such limitations are encountered, his instinctive reaction against them is in direct proportion to the energy of the thwarted wish. If the child be normally impressionable and intelligent ("a proper child") or over-impressionable, the original reaction quickly changes in character. He becomes in time "trained," and takes on the semblance of a passable person. Just here is an important point, which I wish to stress. The early training of an impressionable child "sinks in" and becomes a part of his very self, so that the ideals molded into him at this time motivate his conduct throughout his life. The training of a child is, so far as it is voluntary, an endeavor properly to condition his reflexes, or in other words to teach him good habits and to supply him with what society would call moral ideals. The instincts are not destroyed by any sort of training, but are still there, on the alert for any chance of expressing themselves. In any child culture that is intelligent and purposive, and not merely haphazard, this fact is recognized, and some acceptable outlet for this energy is furnished. But even in the most fortunate cases there is some repression.

There are, then, two necessary parts of the personality—the instincts, caring nothing for society and clamoring with all the energy of the organism for their own satisfaction, and the social beliefs and ideals, saying with equal firmness, "Thou shalt not." What is to be done? It is a situation calling for a sincere and wise diplomacy, and that of the open variety. Up to this point in the individual's development, a normal mental and "nervous" life is still possible. The price of normality is an "open covenant openly arrived at."

But the mutual relations of the nations of the earth are frankness itself in comparison with the tricks and evasions and inconsistencies with which the egotistical instincts bargain with the ideal. The proceedings of this peace conference have engaged the interest of poets and artists since the beginning of human life. Religions and legends have taken this for their central theme. Fairy tale and folk lore are full of the story—the Snake in the Garden of Eden, Saint George and the Dragon, Anthony and the Adversary, the Devil and the Soul of the latest "Twice-born Man."

Normal people go into this struggle with the determination of winning a workable peace. How does the psychoneurotic carry himself here? He is afraid, and he tries to run away.

There are two elements in the reason for his failure. One is a sensitive, over-impressionable nervous organization, and the other is a defective early training. An over-sensitive organism is at the mercy of its environment, and a child of this type reacts to every stimulus with fear. If this fear reaction is not overcome by intellectual curiosity, or by a common-sense relation to the facts of life, or by some other means that will develop in him a normal sense of proportion and balance, the individual's feeling of inadequacy and inferiority will continue to interfere with his adjustment. It is this feeling of inferiority that makes him afraid before the pressure of society, as it makes him fear the imperious demands of his own instincts. He is afraid to do what he thinks wrong, and he is afraid to do what he thinks right, and above all he is afraid to give up the safety of fixed ideals. One of the most characteristic things about the psychoneurotic is his tendency to fixation at a lower developmental level. He cannot grow up in his affective (emotional) life, because each measure of growth involves a giving up, and going out from a cherished place of safety into an untried world. He shrinks from this as one shrinks from a sudden step in the dark, where there is no footing.

We find women of thirty-five or forty holding fast to the ideals of eighteen, showing the romantic sentimentality that at the earlier age is but the sign of an outreaching, healthy personality, going to smash against instinctive desires that should have been achieved or outgrown long ago. Men, after the excuse of some financial reverse, or in an illness, will "act like perfect babies," becoming dependent upon their wives, as they were during early childhood upon their mothers. They have never given up their desire for the protection and safety of their first home. And so the psychoneurotic, in order to escape what seems to him an unbearable situation, tries to slip away unnoticed.

The way in which a particular person runs away will determine the kind of symptoms he will show. Perhaps the simplest way is through a physical pain or discomfort. If one has a headache in the morning, one cannot be expected to get up and face an uninteresting day's work, or to bear with patience the irritability of others, or to force oneself to a difficult moral decision. A sudden feeling of weakness is a remarkably good barrier against the necessity for finishing a painful duty. The experimental work of Cannon, Sherrington, Kempf, and others has shown how easily the autonomic nervous system becomes conditioned for such a service as this. Of course this process is unconscious. This individual, who has over-accepted the high ideals taught him, and who demands of himself a higher standard of conduct than the average, must fool himself before he will be willing to fool anybody else. After the patient has developed some physical pain as a defense reaction, it is easy enough for him to believe the pain to be the cause of his inability for work, especially when he is being told so by the various doctors who treat him so ineffectually. Such a patient is much relieved to have his own occasional doubts overcome by competent authority.

Besides the physical-illness route, there are innumerable other for those people who must have stronger proof of their inability to meet the demands upon them. For the more conscientious individual, a method ready to his hand is mental depression. Of all known means for putting off until to-morrow a decision that should be made to-day, depression is the most effectual. In order to overcome difficulties, one must think about these difficulties. Yet feeling and thinking cannot be done at the same time. One or the other will obtain the "final common afferent pathway" of Crile. So long as the ground can be held by the feeling of depression, all clear thought on the subject must wait. Every time such a person begins to think about the trouble, the depression rushes up and drives away thought. And so the settlement is put off indefinitely.

When the conflict rages so violently as to threaten to arise into consciousness, some will develop serious phobias, compulsions, irritabilities, anxiety states, antipathies, indecisions, memory disturbances, depressions, suspicion, self-depreciation, over-scrupulousness, a general feeling of discomfort, and a vague fear of impending misfortune. Each of these will be found to have a definite origin. But whatever the symptoms, it is necessary that the patient remain unconscious of the connection with his desire to escape, for to bring this thing out into the open is to renew the fight. If the origin of the headache become clear, that way of exit is closed for the future.

So these symptoms are not under the control of the patient's will. It is difficult for laymen, and even for many in the medical profession, to understand this middle ground between organic disease, on the one side, and sheer pretense on the other, and yet the situation is a very definite one, and the patient genuinely ill, for he doesn't really get out of the fight by any of these means. It is merely pushed below the threshold of his consciousness. If you are riding for a head-on collision, you shut your eyes to get away from the impact, but the crash and destruction are not any the less for that. In the case of the psychoneurotic, this shutting the eyes is the cause of the crash.

A psychoneurosis is the expression of an unconscious conflict.

The statement is sometimes made that a nervous patient "enjoys his illness." This enjoyment is comparable to that of a soldier on the firing line, who, while hating his present situation and trying to leave it, stumbles into the enemy's camp. Or, more simply, let us compare it to the enjoyment experienced by the proverbial acrobat, who, finding his position in the frying pan unsatisfactory, seeks relief by taking a header into a very hot fire. The enjoyment is hardly worth mentioning.

The psychoneuroses are not physical diseases, and they are not merely symptoms of physical disease. And they are not curable by physical means. Organic disease lowers the threshold and lessens the repressive power of the individual, and therefore may be the occasion of an outbreak of psychoneurotic symptoms. The real cause, we can see, goes back of any accidental occurrence.

The subject of this paper does not include a detailed description of treatment. From the conception of the cause of these troubles which is stated here, the general principles of the treatment will be obvious. They consist, broadly, in bringing the particular conflict into the consciousness of the patient, and of mobilizing his own moral forces to settle the business once for all, in an arena where clear thinking is the umpire.

The rational treatment demands, first of all, a clear understanding on the part of the physician of the psychological mechanisms involved. It demands a sincere and courageous attempt to determine what the particular patient's difficulty has been. No generalities or platitudes will be of the least use.

Such help as may be in a sympathetic attitude and a desire to soothe the patient is not sufficient for the serious business of curing a really sick person. The general advice to stop worrying, to go out and have a good time, or even to find some interesting work, will never touch the disease itself. Real work on the part of the physician will be required in the problem of finding out each patient's specific weakness and strength. And all the ability and skill that one has will often seem hardly enough to get the answer.

In conclusion let me emphasize the three ideas that I wish to convey:

First: The psychoneuroses are developed on a basis of an over-impressionability of the nervous system, in persons who have not had the kind, or degree, of early training that their particular constitution called for.

Second: The psychoneurosis is dependent upon the individual's conflict within himself, and not directly upon any outward circumstances.

Third: The process by which the symptoms of a psychoneurosis develop is unconscious, and thus is not under the patient's control.

I venture to predict that when the profession at large begins to accept this approach to the study of nervous manifestations of disease, the greatest stumblingblock in practice will disappear. The psychoneurotic will no longer be the helpless and irritating puzzle that he still too often appears, but will rather be one to be studied and helped back to the right way and remade into a valuable asset for the social body.

MENTAL HYGIENE AND THE PUBLIC LIBRARY

MARY VIDA CLARK
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THE public library is assuming increasingly the function of guide, philosopher, and friend to the seeker after knowledge. An example of this amiable intention is an attractive little circular entitled *"Mental Science"* (the quotation marks are a part of the title), a pile of which lay recently for distribution on the desk where books are taken and returned at the public library of one of our half-dozen largest New England cities. The suggested reading on this topic included 74 titles of books by 46 writers. The list began with F. M. Alexander's *Man's Supreme Inheritance* and ended with Elizabeth Wilder's *Self Help and Self Cure,* which the accident of the alphabet placed cheek by jowl with Dr. White's *Principles of Mental Hygiene,* wedged in between this authority and the works of one G. L. Walton entitled *Calm Yourself, Peg Along, Those Nerves, Why Worry?* Between A and W the gamut was run from Ralph Waldo Trine's *In Tune With the Infinite* to William James' *Energies of Men,* from Horace Fletcher's *Menticulture* to Bergson's *Matter and Memory.* The most prolific writers, to each of whom four volumes were credited, were Arnold Bennett, Annie Payson Call, Horatio Willis Dresser, and George Lincoln Walton.

One wonders what would be the state of mental indigestion of an innocent and omnivorous reader who should attempt to consume this strangely assorted pabulum. Perhaps a discriminating person, if such a one could be imagined as tempted by this menu, might distinguish between "the feast of reason" and "the flow of soul" herein partially presented. But what a pity that the discriminating reader should not be found among the staff of the library or its professional advisers! A ribald outsider might be tempted to propose a companion piece to this little sheet entitled *"The Heavens,"* which should list indiscriminately works on astronomy, astrology, and theology.

More recently there was to be found in this same library, obligingly offered for free distribution, a two-page multigraphed list of 25 books entitled *"Hints on Child Training."* In this were included admirable authorities on the so-called moral side, headed by Jane Addams and Felix Adler, and six books on the feeding of infants and children; also such attractive titles as *The Biography of a Baby, Concerning Paul and Fiammetta, The Trend of the Teens, The Girl in Her Teens, The Boy Problem in the Home,* and *The Child and His Religion.* The list did include G. Stanley Hall's *Adolescence,* but this was the only book of its kind.

This is a library which subscribes for MENTAL HYGIENE and the other leading psychological and educational reviews. It is, on the whole, remarkably well equipped with most of the books of the leading psychologists, psychiatrists, and educators of the present day. If one knows what one wants, it is easy to find it in this library; but alas for the seeker after truth who does not know his way about in the particular corner of the field of knowledge that he wishes to explore! The catalogue's classifications are in turn comprehensive to the point of bewilderment and strangely inadequate. "Mind and Body" is a rich classification, with 58 titles of a bewildering variety, and it passes the reader on to other labyrinths by directing him to "See also 'Animal Magnetism,' 'Brain,' 'Dreams,' 'Hypnotism,' 'Idiocy,' Insanity,' 'Mental Healing,' 'Nervous System,' 'Psychology,' 'Psychoanalysis,' 'Sub-Consciousness,' 'Suggestion.' " "Mental Hygiene" is as yet a somewhat arid classification. Under it are listed only the files of the quarterly of that name, the title of a book by one D. A. Gorton—*Essay on the Principles of Mental Hygiene,* published in 1873—and Dr. White's *Mental Hygiene of Childhood.* "Mental Healing" with 77 titles and "Psychic Science" with 62 are perhaps the richest of the classifications, both ranging from the works of Alexander to those of Worcester, and there is even to be found "Psychoanalysis," with the names of the works of Blanchard, Bradby, Brill, Coriat, Freud, Frink, Healy, Holt, Jelliffe, Kempf, Lay, Mordell, Nicoll, O'Higgins, Putnam, Tridon, White, and *mirabile dictu* Southard and Solomon's *Neurosyphilis!*

This library has an admirable system of keeping on open, accessible, and labeled shelves the newer books. Some time ago the two shelves marked "Philosophy" contained 29 volumes, of which nine were on spiritualistic subjects and only one—Dr. Coriat's *What is Psychoanalysis?*—had any relation to the subjects that might be classified under "Mental Hygiene."

Is the situation represented by this library a typical example of our public libraries in general, and, if so, is it not the business of some one to help the generally overworked and underpaid librarians by putting at their disposal more accurate knowledge in this somewhat technical field than they can reasonably be expected to possess or acquire? Lists of books worth purchasing would be helpful, with good advice as to their distribution—for instance, which should be put on shelves for the general public, including the ubiquitous and inquisitive young person, and which should be kept behind locked doors for the use of teachers, pastors, physicians, intelligent parents, and other qualified persons. Perhaps individual physicians and informed laymen might make it their business to look into the state of affairs at their own local library and offer the help that would doubtless be most gratefully accepted by these so conscientious and public-spirited librarians who strive to serve the people of their communities and who heartily deserve the coöperation of those who could do with ease what they naturally can do only with great difficulty. As a means of popular education, there is perhaps no better way than to make readily available the best books on mental hygiene and related topics. Here is a field where a very little effort would probably have great results.

INADEQUATE SOCIAL EXAMINATIONS IN PSYCHOPATHIC CLINICS*

DOROTHY Q. HALE

THE medical profession has found an ever-increasing function for organized social work in connection with hospitals, as is shown in the history of the development of hospital social service in this country. The first need for hospital social service in the United States was felt in the latter half of the nineteenth century, when physicians appealed to the Charity Organization Society for assistance in detecting fraudulent use of free clinics. In 1884, the New York Charity Organization Society "undertook to examine for the German Dispensary the ability to pay for treatment for such of its applicants as were referred."[1] The next step in this country toward a broader duty for the hospital social worker was the after care of patients discharged from hospitals for mental disease. The New York State Charities Aid Association, stimulated by the work of an English association called the Society for After Care of Poor Persons Discharged Recovered from Insane Hospitals, the function of which was to care for discharged patients in the community in close coöperation with the medical superintendent of the hospital, established in 1905 similar work in some of the hospitals for mental disease in that state. From New York the movement spread to many hospitals for mental disease throughout the country.

In the same year, Dr. Richard C. Cabot established at the Massachusetts General Hospital a social-service department, the function of which was to aid the physician in diagnosis and treatment. Miss Ida M. Cannon, in her book *Social Work in Hospitals,* says that Dr. Cabot "found in the social worker a potent means for more accurate diagnosis and more effective treatment."[1] At the present time, this opinion among physicians has spread very widely, and psychiatrists express a general need for the findings of a social examination as an element on which to base their diagnosis and treatment. The purpose of this paper is, however, to raise the question whether a sufficient number of social examinations are made in psychopathic clinics.

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* Submitted and accepted in partial fulfillment of the requirements for the diploma in the Smith College Training School for Social Work, August 30, 1921.

[1] See *Dispensaries: Their Management and Development.* By Michael M. Davis, Jr., and Andrew R. Warner. New York: The Macmillan Company, 1919. p. 44.

The social examination is the collection of social data concerning the patient's past and present life and the bearing of these data upon his present situation. It should include knowledge of the traditions, characteristics, and habits of the group in which the patient has passed his life, as well as information in regard to the manner in which he has reacted to his group standards. The social worker obtains this through interviews with the patient's relatives, friends, and former neighbors, and from professional people, such as the school teacher and the family physician, who have come in contact with him. It is of the utmost importance that she should be able to estimate the value of the information that she collects: the informant, whoever he or she may be, may never have been in a position where he could obtain accurate knowledge of the facts that he is giving; his memory of them may be mistaken; he may be either wilfully or unintentionally misinterpreting them; or he may be deliberately giving misinformation.

The social worker also consults any documentary records that may be pertinent to the case; and here, too, she must be careful to criticize intelligently the source of the record. She observes for herself the actual home conditions of her patient. She has time to cover a field and to develop a technique in regard to the social examination that would be impossible for the busy physician.

Dr. Walter E. Fernald, in his clinic for mental defectives at the Massachusetts School for the Feebleminded at Waverley, makes the social examination a part of the routine of the clinic. In enumerating the hands through which the patient passes in the process of the examination, Dr. Fernald says: "A trained social worker investigates the economic history, the social history, and the evidences of character defects, and immoral or criminal records."[1] Dr. Bernard Glueck, in an article entitled *Special Preparation of the Psychiatric Social Worker,* lays emphasis on the importance of the social investigation to the psychiatrist. He teaches his students "how important it is, for psychiatric diagnosis and treatment, to obtain a reliable picture of the setting from which the patient comes to the psychiatrist."[2] Dr. George H. Kirby, in discussing how social service can be of assistance in the diagnosis and treatment of patients says: "Physicians are realizing more and more the great importance of having a good history in every case before an attempt is made to arrive at a final diagnosis. No part of the entire medical record is more essential than the previous history of the case; in fact, without this information, many cases remain entirely unclear and no diagnosis at all can be made."[3]

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[1] *Social Work in Hospitals; a Contribution to Progressive Medicine.* By Ida M. Cannon. The Survey Associates, 1913. p. 15.

Dr. William L. Russell, in his article *What the State Hospital Can Do in Mental Hygiene,* quotes Dr. Adolf Meyer as follows: "Through the demand for a thorough study of each case, the hospital physicians are confronted over and over again with the need of accurate knowledge of the constellation in which the patient came to grief. This quite naturally led to an attempt to visit the home or have it visited by some one who knew what was wanted."[4]

The above quotations show the theoretic desire of prominent psychiatrists for social service in connection with their work, and the following cases show instances in which physicians actually changed their advice as to the treatment of a patient after receiving a report of the social examination. These cases are selected from four different clinics, and, though one may not draw conclusions from so few cases, it does not seem unlikely that recommendations would frequently be influenced if the data gathered through social examinations were at the disposal of the physician.

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[1] See *The Out-Patient Clinic in Connection with a State Institution for the Feebleminded.* By Walter E. Fernald. MENTAL HYGIENE, October, 1920, p. 850.

[2] See MENTAL HYGIENE, July, 1919, p. 413.

[3] See How Can Social Service in State Hospitals be of Assistance in the Diagnosis and Treatment of Cases? By George H. Kirby. *The State Hospital Quarterly,* February, 1917, p. 183.

[4] See MENTAL HYGIENE, January, 1917, p. 91.

The first case is that of a widow, thirty years old, who had been committed to a psychopathic hospital and discharged on a trial visit to her sister with a diagnosis of manic-depressive insanity, and who was to report at regular intervals to the physician in the out-patient department. As she did not come at the stated time, the follow-up visitor called at her home and saw both the patient and the sister with whom she lived. The patient seemed depressed, and the sister said she had twice been excited since leaving the hospital—once breaking a window and once jumping into a pond in a public park. The sister added that she was unable to take her out to walk as advised by the physician because she herself was always followed by an enemy, a man who lived on the top floor. She became very emotional while talking, and the visitor was not surprised to hear from a third sister that there was no such man, and that she had considered this sister of hers also mentally unbalanced for some time. The third sister was able to get home only once a week, as she was in domestic service.

This situation was unknown to the physician at the time he recommended that the patient be returned to her home. When informed by the social-service department of the conditions surrounding the patient, he recommended placement in a new environment.

The next is the case of a single girl, twenty-two years old, who was brought to a psychopathic clinic for examination. At that time it was known that the patient had been in an ungraded class at school from eight until sixteen years of age, and then had been for several months at a school for mental defectives. After that she had held a position for a year as general housework girl, which she lost because her employer died. In her next position, which she held for a few months, she was very much overworked and finally left because she was assaulted by the man of the house. The physician pronounced her mentally defective; and, because she had held her position as houseworker for a year, recommended housework with some woman who could give supervision. The social worker interviewed the agent of the employment bureau of the Young Women's Christian Association, who was interested in securing positions for handicapped persons, and who thought she could place the patient, but on the day appointed for the patient to visit her, the patient's mother said that she could not possibly go because it was one of her "excited days," and explained that at menstruation she became unmanageable. The mother also said that at her former position, she was never left alone and never given any but the simplest sort of work, such as washing dishes or peeling potatoes. When this additional information was brought to the physician, he decided that it would be unwise to attempt to supervise the patient in the community and recommended that she be sent to a school for the feebleminded.

The third case is that of an epileptic boy, fifteen years old. The mother of the boy came to a social-service office asking advice in regard to his care. She said that she had taken him some months before to the mental clinic of a well-known private hospital, and that the physician had first advised commitment, but had then changed his mind, saying that she should care for him at home. The social worker found that the father of the boy had separated from his wife and was contributing only six dollars a week toward his son's support. The boy was difficult to manage and took all the mother's time and strength, and the only other child—a daughter who was not strong—supported the family. A visit to the clinic physician proved that he knew nothing of the home conditions and, on learning them, he recommended commitment.

Another case is that of an idiot girl, three years old, who is blind and entirely helpless. Her father came to the social worker's office in December, 1920, asking advice about commitment. The patient had been examined the previous summer at the clinic maintained by a department of public welfare, where the diagnosis of idiocy was made, but commitment was not advised although the parents were anxious for this. The social worker telephoned to the department of public welfare and was told that the patient could not be committed because the home was in good condition and the patient the only child to be cared for.

The social worker found that, four months before, the mother's father and two sisters of nineteen and seventeen, and a brother of fourteen, had come from Poland to this country and found no work and no place to live but with the patient's family. The patient's father was out of work and there were no savings, as money had been sent to relatives in Poland. The patient's mother was being treated by a physician, who wrote that she was suffering from general debility and that in his opinion she would not recover as long as the patient, who was heavy and needed constant lifting and handling, was at home. A letter was sent to the department of public welfare stating the situation, and nine days later a letter was received from this department saying that the patient had been sent to a school for the feebleminded.

The fifth and last case shows an instance where the physician changed not only his recommendation, but his diagnosis, as a result of the social examination. An English Jew, thirty-four years old, came to a psychopathic clinic in November, 1920, complaining of many pains and a great feeling of weakness. He was a tall, well-dressed, melancholy-looking man, who made on the whole a very good appearance. He said that he worked for a jeweler, his highest earnings being forty dollars a week. He gave his address and said that he lived with his wife and five children, and that there was some friction between him and his wife. The physician made a diagnosis of hypochondria and gave him a therapeutic talk.

The patient came again to the clinic about a month later and this time saw a different physician. He still complained of a great weakness, and after much questioning he told this physician that his married life was unhappy; that there had never been any love between him and his wife and that he had married her only because she threatened to go to court after the birth of a child by him. He said that she was a very poor housekeeper and refused to take any advice from him in regard to the children. The physician referred the case to the social worker, as he thought that the patient's neurosis would improve if he were freed from anxiety and given a chance to start again. The social worker visited the home and found that the family was living in two dirty, untidy rooms, in one of which they all slept—the daughter of eleven in bed with her parents. The wife, who seemed very unintelligent, and whom the physician later diagnosed as mentally defective, complained that her husband worked for so few days during the week that she had no money to buy food or clothes for the children. The social worker then found that the family had been known to seven different social agencies, including the Society for Prevention of Cruelty to Children. The Jewish relief society first knew them in 1914, when the patient deserted his family for nine months. Shortly after his return, he was sentenced to prison for twice deserting the navy, and was later released in order to support the family, but refused to work, swearing at the vistor who offered to get him a job. It was suspected that he had sexual relations with one of his daughters. A prominent settlement house had also known the family for many years, but had been unable to carry out any plan of relief owing to the unreliability of both the patient and his wife. The man had agreed to get a separation from his wife, but refused to do so at the last moment.

After reading the visitor's report of her investigation, the physician changed his diagnosis from psychoneurosis to constitutional psychopathic inferiority. When the case was brought up in court in an attempt to break up the home and board out the children, instead of recommending to the judge that the patient be given another chance, free from worry, the physician advised that he be given the alternative of supporting the family or going to prison, and said that in his opinion he was an unfit guardian for his children.

The desire expressed by psychiatrists for social examination for their patients, and the actual benefit that was gained by the examination in the above cases and in others similar to them, make an inquiry into the extent of the use of social service in psychiatric clinics seem of interest. A study of the patients who were due to return in February, 1920, to a well-known out-patient department for psychopathic patients showed that of the 184 patients due, thirty-two—17 per cent—were already in the care of an outside social agency when they came to the clinic, and that forty-six—25 per cent—were referred to the social service by the physician in the clinic. The remaining one hundred and six patients—58 per cent—

received no social care beyond what was necessary to insure their regular visits to the physician, and hence no social examination was made. The study made by the writer of the medical histories which were obtained from these one hundred and six patients shows that in forty of them no social difficulty is suggested, but that in sixty-six, or over half of them, a social problem is indicated which it would seem should be investigated to show to what extent adequate care of the patient is handicapped, and to what extent the patient's condition is causing disruption in the home.

Some of the most important factors in these histories can be stated briefly as follows:

Boy of eleven. Diagnosis: manic-depressive insanity. In excited stages of illness runs away. Parents refuse commitment. Large family of other children. Impossible for family to give patient proper attention. Family does not understand situation. A better understanding might have been brought about under continuous social supervision, when at least instruction as to the best care of the boy could be given, and consent to commitment possibly obtained later.

Girl, twelve years old. Diagnosis: hysteria. Patient is "nervous" and scared in the dark. Afraid to read stories or go to the moving pictures, as she thinks of them constantly afterward. Father has heart trouble. Mother is rheumatic. Seven brothers and sisters, the youngest a baby. A social worker could probably help to readjust this patient through supervision, either in her home or in some other family.

Married woman, thirty years old. Diagnosis: psychasthenia. Confused, sad, and depressed. Has thoughts of suicide. Fears husband will divorce her. Apparently her trouble is not understood by her husband, parents, or only brother. Were this a social-service case, the social worker could learn the facts of the situation and instruct the relatives regarding the patient's health, urging them to consult the physician.

Young boy. Diagnosis: chorea. Father dead. Mother treated at nerve clinic for neurasthenia. Away all day at work. Patient goes to the public school from nine until four, and to the Catholic school for the rest of the afternoon. The record suggests the need for better diet and more rest and recreation, which might be obtained through social service.

Young single Jewish girl. Diagnosis: hysteria. Came to this country by herself, has no relatives or companions here, and lives alone in a boarding house. It seems as if the social service might have at least provided companionship and recreation for the patient.

> Young married Jewish woman. Diagnosis: manic-depressive insanity. Came over from Russia a few years ago. Her relatives are all in the old country. She has lost her only child. Her husband is away at work all day, and she lives in a boarding house. This situation would seem to indicate need of supervision of the patient.

> Three young girls with dementia praecox. The parents of the first are well-meaning, intelligent Jews who have no conception of the nature of the disease from which the patient suffers, and at present consider her perfectly well. The mother of the second is on trial visit from a psychopathic hospital, having had a "nervous breakdown," and the mother of the third is of low-grade mentality. It seems as if these patients would have a better chance of improving if their parents could be given insight into their condition, or, if this were impossible, a new environment could be found for them through social service.

Table I (page 803) shows the social symptoms suggested and the medical diagnoses of the patients involved.

A similar study of the patients reporting for six months in a prominent psychopathic clinic in another city gives the following facts. The total number of patients reporting was two hundred and fourteen. One hundred and nineteen of them were in the care of a social agency when they came to the clinic, and thirty-five of them were referred by the physician to a local mental-hygiene committee for social care. Sixty—28 per cent—of them received no social care, and the records of thirty-five of these sixty patients suggested social difficulties which are listed in Table II (page 804).

The last case on the chart, that of the patient whose family was unable to give sufficient supervision, is an excellent example of an instance where the social service apparently could have done something for the patient, had it been called in when the patient first visited the clinic.

An Italian boy, sixteen years old, was brought to the clinic on January 25, 1921, by an elder brother, who impressed the physician as being very intelligent. The boy had run away from home three months previously, and had been brought back two days before by the Traveler's Aid Society, who advised his attendance at the clinic. He had come from Italy with the older brother, eighteen months before, to join his parents and other brothers and sisters, who had been in this

Table I.—Social Symptoms and Medical Diagnoses of Patients Not Cared for by the Social Service, Who Were Due to Report in an Out-patient Department in February, 1920

		MEDICAL DIAGNOSES															
SOCIAL SYMPTOMS	Total	Neurasthenia	Psychasthenia	Hysteria	Dementia praecox	Manic-depressive insanity	Organic brain disease	Arteriosclerosis	Epilepsy	Psychopathic personality	Cerebral embolism	Feebleminded	Hydrocephalus	Alcoholism	Chorea	Diagnosis deferred	No nervous or mental disease
Unemployment (families to support)............................	10	4			1		1		1		1					2	
Responsibility for care of parents with mental disease..............	1		1														
Responsibility for care of small children........................	12	7	2	1	1					1							
Patients separated from their families..........................	13	1	3	1	1	2	1	1		1						2	
Patients with no occupation....................................	5	1		1	1	1			1								
Family has no insight into patient's condition..................	15	2	1	2	3		2		1	1				1	1		1
Family too busy to give adequate care..........................	5					1			1			1	1		1		
Husband not working..	1	1															
Conduct disorder in other members of family.....................	2					1				1							
Home conditions unknown......................................	1													1			
Sex irregularities suspected....................................	1					1											
Total..	66	16	7	5	7	6	4	1	4	4	1	1	1	2	2	4	1

Table II.—Social Symptoms and Medical Diagnoses of Patients Not Cared for by the Social Service, Who Reported at a Psychopathic Clinic for Six Consecutive Months in 1920 and 1921

		Medical Diagnoses									
Social Symptoms	Total	Neurasthenia	Psychasthenia	Hysteria	Dementia praecox	Epilepsy	Psychopathic personality	Alcoholism	Syphilis	Paranoid	Diagnosis deferred
Lack of recreation	3			1	1		1				
Family to support	3	1	1								1
Separation from family	11	3				2	1	2	1		2
Worry about health of other members of family	4	2								1	1
Responsibility for care of small children	1		1								
Improper housing conditions	1										1
Home conditions unknown	2			1							1
Family discord	9	3	2				1	1			2
Family unable to give sufficient supervision	1										1
Total	35	9	4	2	1	2	3	3	1	1	9

country for several years. He had difficulty in speaking English and therefore was graded in school with children much younger than he. He was unhappy there, and his father had allowed him to go to work a few days before he ran away. This was the second time that he had left home. The physician made no diagnosis, but advised the brother to guard the patient in regard to his friends and to keep in touch with the clinic.

The following April, the social worker, in studying a group of clinic records, found that this patient had not reported a second time to the physician. She visited the home and talked with the brother, who said that the patient was neither working nor going to school. He wished him to go to a vocational school as he thought he had a taste for mechanics, but this was impossible because the patient had not passed the required grade in grammar school. The visitor learned from the principal of the boy's school that all the children in the family had a reputation for truancy and that the parents were considered very unreliable; but the teacher who taught the patient said that she had never had any difficulty with him in regard to behavior, and thought his backwardness was due entirely to language difficulty. The visitor then found from the public-school vocational bureau that the patient could be admitted to an evening vocational school if he would agree to work during the day at some job in the trade which the school employment bureau would find for him. In the meantime, however, the boy had again run away and the influence of the clinic was lost.

These facts would seem to indicate that there is a question whether social work is used to as great an extent in psychopathic clinics as its service warrants. In two well-known clinics which have highly organized social-service departments connected with them, the study has shown that many patients whose records point to social conditions that may be deleterious to the patient are not receiving social care. In these two clinics, the general inference is that the social problems of all the patients are investigated and treated by the social service. The writer has heard the following statements made in both clinics by prominent members of the staff when giving a description of the work to a stranger: "If the patient presents a social problem, the case is referred to the social-service department," or, "The social worker looks after the patient if there is a social problem." The charts and specific cases given here suggest that many of the patients who are faced with difficult social problems do not reach the social service, and that because of this the physician loses information that would be of value to him both in making a diagnosis and in formulating plans for treatment.

The studies show a noticeable difference in the proportion of cases cared for by the social service in the two clinics. At the first clinic, 42 per cent of the patients receive this care and at the second 72 per cent. One reason for this difference is that the first study includes all patients due to return to the clinic and does not include those coming only for an examination which is completed in one day. The latter are brought mostly by social workers from an outside agency. Another important reason for the difference is that the clinic manager at the first clinic was not a trained social worker. At the latter clinic, each social worker who was employed by the social-service department was on duty at one clinic a week, and it was quite noticeable in the investigation that at the clinics in which were the most experienced social workers, fewest uncared for social problems were found. If the social worker found symptoms suggestive of a social problem while taking the history from the patient, she felt responsible for consulting the physician in regard to a social examination. In this way the initiative came not only from the physician, but the social worker shared with him the function of recommending to the social-service department every patient who needed social care. Were this carried out, however, a much larger social staff would be required than is employed at present in either of these clinics, where the social workers are frequently working overtime.

EUGENICS AS A FACTOR IN THE PREVENTION OF MENTAL DISEASE*

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THE burden of mental disease is each year becoming heavier. State hospitals for mental disease throughout the country are overcrowded, and the construction of new hospitals does not keep pace with the increase of patients. Fairly complete censuses show that the number of patients with mental disease under treatment in institutions increased from 74,028 in 1890 to 232,680 in 1920. The rate per 100,000 of population increased from 118.2 to 220.1. Careful estimates based on statistics of the New York State Hospital Commission indicate that approximately 1 out of 25 persons becomes insane at some period of life. The economic loss to the United States on account of mental disease, including loss of earnings as well as maintenance of patients, is now over $200,000,000 per year. Although much of the apparent increase in the prevalence of mental disease may be due to causes that do not involve weakened resistance to the stresses of life, the load born by the public is clearly becoming more oppressive.

Associated burdens are those of mental defect, epilepsy, dependency, and delinquency. These combined cause an economic loss even greater than that caused by mental disease.

Taxpayers are groaning under excessive loads and calling in vain for relief, but their cries are faint compared with those of the persons whose relatives are mentally diseased or defective.

As less than one-fourth of those who develop psychoses can be cured by present methods of treatment, we cannot hope for any permanent relief by treating patients in hospitals. The most skillful treatment should of course be given, but the problem must be attacked in other ways before any adequate solution can be hoped for.

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* Read before the Section on Eugenics and the State of the Second International Eugenics Congress, New York City, September 26, 1921.

The fact of inheritance of the neuropathic constitution may be taken for granted. Much evidence has been adduced to prove that such inheritance occurs in accordance with Mendelian laws, but the subject is so complicated that more comprehensive studies must be made before we may consider the matter as settled. The application of skillfully devised measures of intelligence has shown us that there are many grades of intelligence between the idiot and the super-average. The so-called normals represent many types, the extremes of which are as far apart as the moron is from the low-grade normal. Recent studies of temperamental abnormalities have also revealed a wide variety of types and combinations. These abnormalities or marked peculiarities seem to be more or less dissociated from intellectual capacity. Children with super-average intelligence are frequently seclusive and morons often seem to be temperamentally normal. It becomes difficult, therefore, to establish standards of normality and to draw fixed lines between the normal and the neuropathic. This is especially true in studying family histories, when judgment must be based on reports of untrained observers. Mental disease may occur in a person of almost any type of intellectual or temperamental make-up. This fact was clearly demonstrated during the recent World War. Men of strong intellect and of exceptional poise who had withstood the strain of intense warfare for several months at last succumbed when weakened by wounds and deprivation of food and drink. These were extreme cases, but they illustrate the important principle that all men have limitations and may develop a psychosis or expire when their limit is reached. Psychopathic personalities give way to the common stresses of life, while stronger personalities yield only to extraordinary mental strain. It is evident, therefore, that the whole etiology of a case of mental disease must be carefully studied before the related family stock can be safely discredited.

The data we have collected in the New York State Hospital Commission relative to the family history of patients seem to indicate that slightly more than half of our ascertained cases have no discoverable hereditary basis. If more thorough inquiries were made, the proportion of patients with unfavorable family history might be increased, but the significance of the history in relation to the family stock is open to question in many cases.

In our hospitals for some years past, we have studied both the intellectual and temperamental make-up of the first admissions and have tried to apply uniform standards throughout the service. In 1920 it was found that of the ascertained cases 61 per cent were temperamentally normal and 88 per cent were rated as intellectually normal. Only about 7 per cent of the patients were both temperamentally and intellectually abnormal. The proportion of patients with abnormal make-up varied considerably in the different groups of psychoses. For example, in the dementia-praecox group in 1920, 61 per cent were rated as temperamentally abnormal while in the manic-depressive group only 33 per cent were so rated.

The absence of marked abnormalities in individuals prior to the onset of the psychosis cannot be construed as conclusive evidence that there are no hereditary defects in the make-up, neither can the development of the psychosis be taken as proof of a defective constitution. All the facts in connection with the onset of the mental disorder and previous reactions must be brought together before the constitutional make-up of the patient can be positively determined.

Psychiatrists have recently emphasized the connection between bodily states and behavior and the importance of the sexual and endocrine organs in relation to the psychoses. What part of the disorders related to these organs is due to hereditary and what part to environmental factors have yet to be determined.

Notwithstanding these and many other complications, there is abundant evidence that mental disorders occur much more frequently in some family stocks than in others, and that prolonged inbreeding of degenerate stocks is productive of most disastrous results.

With the limited knowledge at hand, what is to be done to lessen the burdens imposed on society by the prevalence of mental disease?

Three lines of action are suggested:

1. Environmental stresses may be lessened and natural resistance strengthened.
2. Procreation of defective stock may be checked.
3. Procreation of normal stock may be increased.

The methods now in use to prevent physical disease may be applied to a considerable extent in preventing mental disease. They include the dissemination of knowledge of hygiene and sanitation, prompt treatment of incipient diseases, segregation of those suffering from contagious diseases, and immunization of those liable to exposure to pathogenic germs. Another line of attack consists in safeguarding the public from injurious food and artificial beverages and from polluted air and water. The abolition of the liquor traffic and the movement to check the spread of syphilis are examples of effective work along these lines.

Economic and social stresses should be lightened for those unable to withstand them. It is far easier to relieve an overburdened man by taking part of his load than to wait until he is exhausted and then carry him together with his burden. Physicians, parents, and teachers should be alert to detect signs of mental disorder and apply the proper remedy before complete breakdown occurs.

Mental clinics and social workers are of large service in giving treatment in incipient cases. Many a case of mental disease is averted by adjusting the environment to the individual and by giving him a clear understanding of his mental difficulties and the best methods of meeting them. Wide extension of mental-clinic work is clearly indicated.

The new science of mental hygiene is teaching us that individuals with unfavorable heredity may do much to overcome their constitutional tendencies and to preserve their mental health. It is of the highest importance, therefore, that mental hygiene be taught and practiced in the public schools along with physical hygiene.

A decade ago sterilization of defectives was widely advocated and laws making provision for it were passed in several states. These measures have availed little because they have not been supported by active public sentiment. Judging from the present outlook, we cannot hope that sterilization will soon be an effective means of preventing mental disease.

Segregation of the mentally defective and epileptic is the prevailing method of limiting procreation among these classes. Its eugenic value is beyond question, but the enormous cost limits its application. As a rule the mental defectives and epileptics cared for in institutions are of low grade. These, if left at liberty, would multiply far less than those of higher grade. Much is to be hoped from the colony plan of segregating mental defectives, as colonies care for high-grade defectives and under wise management become self-supporting and may be increased without limit.

A new departure has been made by the state of New York in establishing a separate institution for defective delinquents at Napanoch. This troublesome group has been a serious problem in the jails and prisons of the state, and heretofore there has been no satisfactory way of dealing with them. Their segregation should have large eugenic significance.

Segregation of the insane is fairly complete, but as only about one-fourth of the first admissions are under thirty years of age on admission, its value in preventing procreation in this group is not as great as would appear when only the number of patients under treatment is considered. Overcrowding and the expense of maintenance cause patients to be promptly released on improvement of their mental condition, regardless of the eugenic factors involved.

Something can be done to lessen reproduction among the unfit by enlightened public sentiment and by better marriage laws. Marriage of persons with marked intellectual or temperamental abnormalities should be entirely prohibited.

To prevent the marriage of normal persons with those carrying a neuropathic taint more knowledge of family stocks must be made available. At the present time genealogical records of the average family are woefully meager and comparatively few are available for public inspection. If we are to improve the race by better marriages, genealogical or eugenic bureaus must be established in cities and villages. Data concerning family stocks should show the defects as well as the excellencies and achievements of the individuals recorded and be available to interested parties.

Love is proverbially blind, but few normal persons would be rash enough knowingly to join fortunes with a neuropathic or degenerate family stock. Unfortunately very little thought is now given to the eugenic significance of marriage and few signs warn impetuous youth of the danger ahead.

Eugenic bureaus, by collecting data concerning family histories and by emphasizing the importance of family stock, would naturally promote marriages among persons of good stock and thereby increase procreation of a desirable kind. The increase of good stock would raise the general level of the race, even if there were no decrease of poor stock, but we may safely assume that more definite knowledge would gradually lessen reproduction among the unfit.

The elimination of mental defects and diseases is after all principally a matter of education. We must learn by careful research what should be done and what should not be done and then disseminate the information so that it will be shared by every household. Action will slowly follow knowledge, but ultimately a more perfect race will be evolved.

MENTAL HYGIENE PROBLEMS OF MALADJUSTED CHILDREN AS SEEN IN A PUBLIC CLINIC*

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IN the Wayne County Psychopathic Clinic at Detroit, which is an out-patient service of the State Psychopathic Hospital at the University of Michigan, most of the children seen have been delinquent in one way or another, and are sent to the clinic for examination by the Juvenile Division of the Probate Court of Wayne County. From this it may be seen that the maladjustment present is often of a rather severe degree and of long standing.

As we go deeply into the study of individual cases, we frequently find that the treatment indicated to bring about a satisfactory solution of the problem at hand does not need to be applied to the patient himself so much as it does to those with whom he lives. It has likewise been often observed by judges of juvenile courts that disciplinary measures are very frequently indicated for the parents, rather than for the accused juvenile. We dislike very much to recommend a commitment to an institution for any child, unless there is a positive indication for it. The types of cases in which positive indications are most frequently seen are, first, those in which the child is so great a menace to the community that it seems advisable to confine him for the protection of the community; and second, those which are in need of the treatment afforded at a particular institution.

It sometimes becomes necessary, however, to institutionalize a child, not because he is in need of any particular treatment that the institution can give him, but rather to remove him from the pernicious influence of his home. An example of this type of case was a fifteen-year-old Jewish boy who was arrested for the third time, charged with larceny, the complaint having been filed by his brother-in-law. The family history showed little of importance so far as nervous or mental disorder is concerned. His mother died of Bright's disease when he was seven years of age. She was a midwife and was described as a very bright woman. His father is a carpenter and cabinet maker and an industrious worker. He remarried shortly after his first wife's death. The patient has one sister and one brother in the army. There is also one half-brother and one half-sister at home. While his mother was living, our patient was given a weekly allowance and, as he put it, "he had to mind." With the entrance into the family of the stepmother, this allowance was stopped. It was then noted that he began stealing, first at home and later outside the home. His stealing led to lying about his thefts. This condition of affairs had been going on for years until more recently he had become truant from home.

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*Read before the Mental Hygiene Section of the National Conference of Social Work, Milwaukee, June 27, 1921. The author wishes to express his appreciation of the kindness of Dr. Nellie L. Perkins and the Wayne County Psychopathic Clinic in extending to him the use of their case histories.

An examination of the boy showed him to have a mental age of thirteen years, with an intelligence quotient of 90, on the Stanford scale—hardly a rating that would classify him as feebleminded. In the emotional field, there was present a little indifference, with some irritability. He had exhibited temperamental outbursts upon occasion when crossed. His attitude toward his stealing was careless, to say the least. He said that he could stop stealing if he wished, but what was the use? In school work, he had reached the ninth grade and had shown a very marked interest in things mechanical.

Investigation of the home showed a six-room house literally filled with roomers, so that the family of five was crowded into three rooms, and even in these rooms the roomers interfered. His stepmother nagged him constantly and showed openly her favor to her own two children. When this condition of affairs became intolerable, he ran away from home and went to his married sister, of whom he was very fond. Here he found that she and her husband frequently quarreled, and in their disagreements he always united with her against her husband. This led to a great bitterness on the part of his brother-in-law toward our patient, and they frequently came to blows. Probation in this case had failed, as we might have expected, in the only two environments available to him. His temperamental peculiarities made him a difficult case in any home, but we had the feeling that in an understanding and stimulating home environment he would grow into a very useful and straight-living citizen, probably an electrician or mechanic. He was committed to an institution, not so much because he needed to be segregated or because we believed he needed the treatment that the institution afforded, but rather because the institution would be better for him than the other environments available.

An example of the type of case in which treatment appears indicated for the parents rather than for the patient is that of a ten-year-old girl referred to the clinic by the Children's Aid Society because she was reported to be of an extremely jealous disposition with a violent temper. She was described as being extremely profane, and at times brutal toward the other children, and was said to have lied and stolen. Her mother described her as uncontrollable, and expressed a fear that the child would kill the other children. On one occasion she is said to have struck her sister with a clothes hanger so that the sister was unconscious for a period of three hours. She frequently told her mother that she wished her mother would die, but she showed great fondness for her father. She is said to have cursed aloud in church, to the great embarrassment of the rest of the family. This sort of conduct is said to have characterized her for a period of about two years, or since the death of a brother. At the time of her brother's death, there was much illness in the family, and the patient was taken by a cousin for a period of two months. It was upon the return home from the cousin's house that this conduct was noted, and it was attributed by the mother to the fact that the cousin had spoiled her. At any rate, the child always wanted to return to the cousin, but this was not permitted by the parents.

The family history in this case indicates that the father and one paternal uncle are heavily alcoholic; the mother, also a patient of the clinic, is definitely psychotic, falling in that class of cases which we have been in the habit of labeling paranoid. There are two other living children. The patient has had the usual diseases of childhood, but has always enjoyed average health. She reached the A Third grade in school, was able to do the school work well, and had caused little trouble in school.

Upon examination she was noted as a frail, timid little girl, with easy recourse to tears. She cried as she told of her efforts to please her mother and of her failures in this regard. She admitted stealing money from the home to buy food because she was hungry. Upon psychometric examination she registered nine years, five months, with an intelligence quotient of 100. During a portion of her examination, the mother was in the room, and the mother's extremely profane description of the patient's conduct caused the child to appear very much ashamed. This child was placed in a boarding home, where she is reported to be getting along well. In this case we have a timid, unstable, very sensitive child, living in a home with an indulgent, weak, alcoholic father and an irritable, paranoid mother. If active therapeutic measures are indicated in the case at all, they are more needed for the parents than for the child.

This case may serve to illustrate another point: The taint in the stock from which this girl comes is such that we need not be surprised if she develops actual nervous or mental disease long after she has left the influence of her home. We are now dealing, in her case, with a problem of maladjustment largely environmental, but due mainly to abnormality in the parents. Who can say that we will not, at some future time, have to deal with a psychosis in this patient for which the predisposing cause, at least, is the same as the cause of the environmental factors at work now?

In public clinics, where large numbers of the poor and unsuccessful are seen, there comes to our attention a rather definite group of cases in whom the situation appears hopeless. I believe that every public clinic has a rather fixed number of these individuals, the percentage differing, perhaps, for different localities, but always present. I refer to the type of case in which the stock from which the patient comes is extremely badly tainted with pathological factors and where the patient carries evidences in his own make-up of his poor heredity to such an extent as to make it appear that he cannot make the necessary adjustment to get along without supervision.

One of this type appears, I believe, in the case of a boy fourteen years of age, a charge of the juvenile court because he had stolen a valuable gold pin set with diamonds. He tried to dispose of it at a jeweler's, but the jeweler became suspicious and accused him of stealing it. He then broke it up and tried at another jeweler's to dispose of it as junk, but was again refused. He had been stealing since he was a tiny boy, but his parents had paid little attention to it until the last five years, when they felt it had become more serious. He had taken a number of pieces of jewelry and as much as $68.00 in money at one time.

His family history indicates that his mother is a very unstable, neurotic woman who has had a nervous breakdown in which she was depressed and suicidal. Although I do not know the exact nature of her trouble, I feel that it was probably an attack of manic-depressive psychosis, depressed phase. The father is a very ignorant man who is extremely indifferent toward his children. He takes no interest whatever in the home and spends all his spare time at lodges. One brother of the patient is subnormal and is in a special class at school. Another brother is well now, but has formerly had convulsions of one sort or another. The maternal grandmother died insane of general paresis. The maternal grandfather was highly nervous and subject to periodic headaches, the exact nature of which we do not know. One maternal uncle was heavily alcoholic. The maternal great-grandfather was also heavily alcoholic. Two of the maternal great-aunts were religious fanatics, thought by many to be insane. On the paternal side the grandmother died insane in the state hospital; the grandfather was a drinker and was well known in the community for his violent temper. An uncle was heavily alcoholic and a cousin was considered an incorrigible thief. The patient was a bed-wetter and a masturbator until shortly before we saw him. He had had pneumonia twice and some of the diseases of childhood. He had attended school regularly.

Upon examination he showed a very narrow, peculiarly shaped head, skin of very fine texture, and disproportionately long extremities. His physical appearance suggested somewhat a disturbance of function of the glands of internal secretion. The neurological examination failed to reveal any definite evidences of organic nervous disease. The psychometric examination gave him a mental age of ten years, ten months, with an intelligence quotient of 76. In the emotional field he showed a striking indifference. There was no evidence present of any affection for his parents and no interest in the probable outcome of his case. He talked freely of his stealing, but without spontaneity, made no promises as to the future, and showed no shame concerning the past. While I am inclined to believe that, in general, we perhaps attach too great importance to a poor heredity when we seek out the causes of maladjustment, still in this case, presenting at least thirteen instances of abnormality in the antecedents, I feel that the heredity factors must be regarded as of considerable importance. This seems to me to be especially true in view of the patient's peculiar physical structure, his subnormality in intelligence, and his total lack of any spontaneity. Certainly the background upon which one has to build in this type of case is of very poor quality, and we must not feel surprised or disappointed to find that effort expended on such material may bear little fruit. We cannot make thoroughbreds out of scrub stock amongst the lower animals; neither can we expect to do so in the human race. A proper recognition of this fact in a public psychopathic clinic is very necessary. There is so much to be done, the cases of maladjustment are so numerous, that the community may best be served by expending our efforts, which are extremely limited, upon those cases where there appears some degree of hopefulness, as a result of our efforts. For the others I would suggest a disposition by the most economical social means possible.

This seems to me to be a distinctly selfish age in which we live. Whether our selfishness is explained by the war or by after-war conditions I do not feel able to say, but we find evidences of it in our public clinics, to which more and more people bring their problems. It is not infrequently observed that children are brought to the clinic, not so much for the benefit which the parents feel might be given the child, but with the expectation that the clinics will, by some means or other, relieve the family of its responsibility toward the child. I feel sure that many children are not wanted in the home. The furious rate at which we live, with its keen commercial competition, tends to make the advent of children into the home an expense that parents too frequently deplore. Under such conditions, the child is apt to be neglected and is hastened to the actual maladjustment for which he comes to the clinic.

I recall the case of a thirteen-year-old girl whose father owned a small delicatessen store. In their eagerness to get ahead financially, the mother spent most of her time with the father in the store, which was kept open twelve to fourteen hours each day. As business increased, the child was also recruited as a clerk. There was no home life. The family's entire life was spent in the store or in the one room behind the store, which served as the home. Small amounts of money began to be missed from the cash register, and it was discovered that the child was taking money to buy small luxuries for herself. The parents brought this girl to the clinic. Their attitude showed that they really wished the clinic might have the girl committed to an institution, so that they might be relieved of the responsibility and be insured against the danger of her further stealing from them.

I feel that we must strive to get away from our cliff-dwelling habit and restore, so far as possible, the family group and the home as an institution. Parents must inject into their children, from the earliest age, a sense of social values. This must be done, not only by teaching in the school and in the home, but by the actual living examples of the parents. We, as workers interested in social-welfare problems, should instill, so far as it is within our power, a proper sense of social values in the cases of those with whom we come in contact, and we must not tolerate the habit on the part of the family of "passing the buck" to the social agency in regard to the entire care of one of its members. We must require of them more in the way of their duty to their children than we have been requiring in the past.

SPEECH DEFECTS IN SCHOOL CHILDREN *

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THE value of easy, smooth, intelligent speech has not been appreciated in the curricula of our public schools. Much more stress is laid upon oral reading than upon the possession by the child of good speech. And even where the child has a definite defect of speech so serious that he cannot get along in the social world, teachers and even parents often place the school training in geography or grammar above the necessity of acquiring good speech. This attitude on the part of teachers and parents may be accounted for as due to a lack of realization of the nature of speech and its social value. Only recently a teacher refused to allow a boy with a bad stutter to have leave during part of one class period in English literature that he might come to our clinic for treatment; she said that the class work was the most important thing.

If we think of man as an adaptive mechanism, constantly adapting to new and untried situations, then it is clear that speech is one of the chief and most important means that man has of so adapting himself. Speech is a short cut to action. A deaf child who has not been taught speech affords a pathetic and graphic illustration of the importance of this function. Instead of saying: "Mama, I want to go downtown," it has to run to the door, point, and make inarticulate sounds, the tones of which express certain emotions, or it may make more elaborate gestures, going out to the automobile, opening the door, etc.

By speech, too, we can bring to the mind of the listener distant scenes, describing actions or individuals, and so speech may be said to be a distance ceptor.

Speech, with its modulations, symbolic words, and accompanying gestures, is developed in response to certain needs in the life of the child. The development of speech is bound up with the development of the intelligence. Some psychologists have claimed that thought is merely subvocal or silent speech.

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* Read before the Mental Hygiene Section of the National Conference of Social Work, Milwaukee, June 29, 1921.

In arguing for the necessity of good speech, I do not speak from the standpoint of the elocutionist who seeks technical perfection. I mean merely speech that is free from obvious defects and that can be understood. The social value of such speech cannot be overestimated. Defects prevent individuals from taking their place among their fellows. They are likely to develop a feeling of inferiority, anxiety states that bring them into the province of the psychiatrist and the psychiatric social worker. What chance has a boy or girl of average intelligence, with no influence back of them, to succeed socially or economically if they have a stutter or cannot speak so that they can be understood? Their powers of adaptability have been cut off at the very source.

And, even if we eliminate the economic side and consider the matter from the viewpoint of mental hygiene, these defects would merit our consideration. Science has studied the most insignificant reactions of the human body, but has almost totally neglected the disorders of speech. As a result, a body of charlatans, quacks, and well-meaning, but uninformed persons treat these speech disorders. Part of the distress from which the individual with a disorder of speech suffers is due to the lack of understanding that he meets. After he has suffered several operations and been treated in a few stuttering schools, his despondency and depression are easily understood.

The prevalence of disorders of speech is astonishing, so much so that the uninitiated are likely to be doubtful of assertions concerning them. In a survey of approximately 5,000 children of Madison, Wisconsin, in the grades below the high school, 5.69 per cent were found to be suffering from disorders of speech. Of this number .72 per cent were stutterers.

J. E. W. Wallin, Director of the Psycho-Educational Clinic in St. Louis, found that out of 89,057 pupils 2.8 per cent had some disorders of speech. Wallin found that .7 per cent stuttered. Conradi investigated six cities and found .87 per cent of stutterers. The average percentage of stuttering from many surveys in this country and abroad is approximately .9 per cent.

Miss Pauline Camp, in a personal survey of 9,387 children in the grades below the high school in Grand Rapids, Michigan, found that 2.64 per cent stuttered and that a total of 13 per cent showed speech disorders.

It is usually claimed that most of the children who have disorders of speech overcome them. In order to determine the number who reach the age of eighteen retaining their defect, a personal examination was made of 1,400 members of the freshman class at the University of Wisconsin. On this basis the 2,240 members of the whole freshman class were computed to have 409 speech defects. One hundred and twenty-five stuttered; 33 had a foreign accent acquired outside of America; 29 had oral inactivity; 103 could not pronounce the letter s or z; 18 spoke abnormally rapidly or slowly; and 101 had severe vocal defects, such as weak, chronically hoarse, husky, or nasal voices. In all, 409, or 18.13 per cent, were found to be unable to meet the necessities of English speech. I should like to add that the examiners were most lenient in their judgment. It will be seen from these figures that speech disorders are not outgrown in any great degree, and in the case of stutterers, even though the speech defect disappears, there remains the defect in the emotions—an undue sensitiveness, a feeling of inferiority which interferes with the progress of the individual. Many of these stuttering cases had a very slight defect, but they felt that they had severe difficulty and maintained that it was a great handicap for them because they never knew when they were going to have trouble with a word, and meeting people was a constant strain on them.

DELAYED SPEECH

A not inconsiderable number of children come to kindergarten and first grade who have not developed speech. Most of these cases are due to a lack of mental development, and each case should have a careful examination to determine its mental level. A certain number of these cases are due to a faulty attitude on the part of the parents. As has been said, speech develops in response to certain needs. In some neurotic children, unless the need for speech is very definite, speech does not develop. A boy of five years with no speech was the only child in a family in which there were, in addition to the parents, the grandparents on both sides. These six adults made every effort in the world to satisfy the child's slightest wish. In addition to this, he had also a nurse, whose sole business it was to look after his wants. This child gave every appearance of good intelligence and, after a few weeks of good routine in his own home, spoke freely and with very few defects, a fact that indicated the use of speech subvocally.

ORAL INACTIVITY

The second type of speech disorder we have called oral inactivity. It is characterized by a lack of coördination of the active elements of articulation—the tongue, soft palate, lips, throat, and jaw. There are several types of this, both from the descriptive viewpoint and from the viewpoint of causative factors. It has been our experience that where the tongue lies more or less inactive on the floor of the mouth, there is likely to be a history of endocrine disorder in the family, of food deficiency of certain of the vitamine-bearing foods, and of temperaments more or less erratic, timid, and egoistic.

This is nicely demonstrated in a boy of nine, who has such peculiar speech that it is not always recognized as English. It is very difficult to understand, due to the omission of nearly all final consonant sounds and to the interchangeable use of several of them. In addition to this there is a distortion of certain sounds, the result of which is unenglish. This boy's family shows a history of hyperthyroidism; his food peculiarities are very marked, his diet consisting almost entirely of carbohydrates; and the behavior of both the patient and his family gives evidence of a markedly neurotic disposition. This child, when concentrated on in class-room phonetics and reading, broke down into a severe stutter. This we find to be a constant occurrence with this type of disorder.

The over-emotional element is nicely shown in one case in which, on the slightest excitement, there is crying, neurotic vomiting, and sleeplessness. This boy is fifteen years of age, and his speech is hardly understandable because of a severe oral inactivity, to which has been added, in the fifth grade, a mild stutter.

In those cases where the inactivity is decidedly in the jaw and lips, the trouble is usually purely emotional, and the temperament excessively timid and inclined to be seclusive and introspective.

LETTER SUBSTITUTIONS

The third type of disorder is called letter substitution. This includes lisping, which is usually the substitution of *th* and *sh* for *s,* and lalling, which is the substitution of *l* and *w* for the consonant *r*. As these two groups did not include all the noticed substitutions, the one name was given to the entire group, and it includes such previously unnoted substitutions as *t* for *k, ig* for *ing, d* for *t,* etc.

An interesting thing in connection with this group is the fact that these changes do not remain constant in all cases. For instance, one child substitutes *k* for *t* and in some positions *t* for *k*. Only rarely is the case found in which the letter sound or combination of letter sounds cannot be made under some conditions. Only in a case where a single letter was uniformly mismade would we be justified in even suspecting the fault to lie in the organic structure, and only then if similar sounds, using related muscle groups, were mismade in a like manner. To illustrate: the tongue position for the letter *s* and the letter *z* are the same; a large number of those who mismake the letter *s* make the letter *z* with ease, although the only added element is vocalization. What, then, would be gained by the changing of the organic structure of the mouth by the application of braces or of operative procedure? The difficulty obviously lies (1) in the intelligence necessary for, or the opportunity for, the learning of the position of the letters in the words, or (2) in the emotional inability to adjust to the necessity of accurate speech. In a case of letter substitution reared in a family where such substitution was constantly present, the lack of opportunity for learning might be postulated. But it must be borne in mind that these people are constantly coming in contact with people who have all the letter sounds, and that infantile speech is a sure tie with infancy, and, finally, that this symptom is rarely present in an individual who does not show other indications of infantile fixations of the emotional life.

STUTTERING

Stuttering, with which we include stammering, is the most serious of the group of functional speech disorders. It is present in about 1 per cent of the school population. This disorder should be considered as symptomatic only. The underlying trouble may be neurotic, psychoneurotic, or some as yet obscure trouble in the control or coördination of the elaborate mechanism of speech.

We feel that there is some lack of balance in the motor control of all these cases, but the most important thing is the temperamental lack of ability to make the necessary emotional adjustments to life and the use of speech as a symbol of all the human relationships. In other words, the fear from which the stutterer suffers is not a fear of speech, but a fear of meeting situations in life, and speech is the accepted field for such a symbolization because poor speech closes the necessary avenue of approach to life and offers an excuse for failure that would otherwise be lacking.

A case that illustrates this is that of a young man of good intelligence and excellent personality who gives the following history: He was the youngest of a family of six children. On the death of the father, the oldest brother came to the head of the family and was constantly pointed out by the mother for his successes and perfections. In this family the standard for scholarship, for personal relationships, for order, and for social success was very high. The patient was somewhat different from the others in temperament and ability, but was held to the same standards. He was late in talking; in his fifth year, when he began to talk, he also began to stutter badly. This stutter was his all-powerful excuse for his failure in family standing. Away from the family, and the comparison with its other members, he has only a little trouble with his speech until some difficult situation arises, and then the condition becomes bad again. In this way he has lived the life of a refined nomad, wandering from situation to situation and from school to school.

A second case is that of a child of two and a half who was forced into a premature conspicuousness by an over-fond and indiscreet parent. This child began to stutter, and *at the same time* began to demand that he be permitted to sleep with the mother and to refuse all but a more or less infantile diet, and preferred staying alone to playing with the children with whom it had been his custom to play.

It is maintained by some workers in the field that the mental condition and the emotional conditions are the result of, and not the cause of, stuttering. It would be true, of course, that the difficulty would carry with it a large amount of unpleasant emotional tone, but it is a significant fact that the families of these people show the same temperaments, the same social disabilities, to a somewhat greater extent than do the families of non-handicapped children.

When you consider that 200,000 children of school age stutter or stammer in this country and that, including delayed speech, oral inactivity, letter substitution, and the most severe vocal defects, there are probably half a million suffering from defects of speech, something of the enormity of the lost opportunity and wasted material becomes apparent.

That this enormous problem can be handled successfully in a way that considers its functional, especially its emotional, element has been demonstrated in such cities as Grand Rapids, Michigan, where the approach to the cases is made almost wholly with a view to adjusting the individual to his environment. Teachers and social workers who undertake this work should know more than the anatomy and physiology of the articulative organs. They should be familiar with the mechanism of hysteria, of the faulty balance and the emotionalism of the neurotic, of the earliest beginnings of aboulia, of negativism, of introversion, as well as the lesser train of timidities and insecurities and over-attachments.

Speech correction offers one of the best methods of approach to mental hygiene in the schools. As yet our boards of education are too hard pressed for money and time to take over the problem as one of atypical behavior. They do see, more and more, the pressing problem of faulty speech, and the organizations for the correction of this defect may well include the incidental care of other children in whom behavior of other sorts is not average.

The teachers who do the speech-corrective work should have, besides a knowledge of the physiology of the organs of speech, a knowledge of speech drill and a thorough training in behavioristic psychology and the psychology of the emotions. They should know the part speech plays in the development of the emotions, and how poorly controlled emotions may develop wrong types of speech. Moreover, they must be trained to understand some of the mental mechanisms that control behavior, such as feelings of inferiority and its compensations in over-boldness and over-talkativeness, and be able to analyze and treat these conditions. Teachers so trained can do mental-hygiene work of the highest type, for they deal with children who have great possibilities.

EXTRA-INSTITUTIONAL CARE OF MENTAL DEFECTIVES*

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THE New York State Commission for Mental Defectives and the New York State Hospital Commission have, within the last two years, coöperated in the establishment of a number of out-patient clinics.[1] It is desired to present here the experience of the last year or so in four of these clinics held monthly in four different cities. As there are present in each clinic a physician from one of the state hospitals and his field worker, as well as the examiner in mental defect and the psychometric tester, children showing signs of mental disease are referred to the state-hospital physician. The problems presented by these children will not, therefore, be included in this discussion.

Several days before a clinic is held, notices of the session are published in all the local newspapers. These notices inform the public of the purpose, location, and the time of the clinic and invite any persons interested in an abnormal, unusual, backward, or nervous child to avail themselves of the services of the clinic. Notices of this character are also sent to the local agencies interested in children, such as the child-placing agencies, county agents for the State Charities Aid Association, detention homes, school nurses, etc.

Before the first clinic is held in any locality, the physicians of the city and vicinity are either written to or interviewed, the purpose of the clinic is explained to them, and their coöperation is invited. After the clinic is organized, these physicians are reminded of the clinic as frequently as possible. No medicines or prescriptions are given to any patients interviewed and the patients who need either medical or surgical care are advised to return to their family physician. This physician is written to by the examiner, if the patient's parent or guardian so requests.

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* Read before the American Association for the Study of the Feebleminded, Boston, May 28, 1921.

[1] *Clinics for Mental Defectives in the State of New York.* By William C. Sandy. MENTAL HYGIENE, Vol. 4, pp. 597-604, July, 1920.

A complete record of each examination is kept and those referring patients are requested to report to the clinic the progress or lack of progress made by the patient; very frequently patients are asked to return for further observation.

All cases coming to the clinic are expected to be accompanied by some one able to give the examiner a complete personal and family history. Whenever the needed history is not secured, as much of an examination as possible is made, but no diagnosis is attempted until the proper history is received and, when necessary, the patient is reëxamined.

Patients are examined in as nearly the order of their arrival as possible. While the examiner is securing the patient's history, the patient is being given the Terman revision of the Binet test, so that by the time the examiner is ready for the patient, the test report is usually ready for him. The examination includes as complete a physical examination as possible as well as a study of the patient's mental activities, knowledge, etc.

In only a very small percentage of cases does the physical examination fail to show several minor, correctable physical defects; not infrequently major physical troubles, such as tuberculosis and heart lesions, are found. When the provisional diagnosis has been determined, the person referring the case is again interviewed and given the examiner's opinion of the patient and such advice as the examiner feels would be of benefit in improving the patient's mental, physical, or social condition. Institutional care is recommended only as a last resort and, in spite of the fact that a number of patients have been presented to the clinic for diagnosis with institutional commitment in view, application for commitment has seldom been made. Where commitment has been recommended, there have usually been reasons external to the patient, such as unusually poor family conditions; that the patient might have the proper supervision and care and thereby a chance to improve, institutional or colony life has been considered.

The first clinic of which I wish to speak is located in a progressive city of about 30,000 inhabitants. Clinics are held in this city two days in each month, the first day in the city hospital and the second day in the Catholic hospital. In each hospital a waiting room and two examination rooms are provided. The first session of the section for defectives of this clinic was held in August, 1919, in connection with a mental clinic that had been established by the State Hospital Commission several years before.

Owing to the fact that neither of these local hospitals has any connection with a free dispensary or other clinics, there is no suggestion of charity connected with an interview in the mental clinic and, as a result, patients have been drawn from all classes of society, ranging all the way from the child of a weathy state official to representatives of the pauper and criminal classes. Patients of the last groups, of course, were presented for examination by social agencies.

For some reason, which I believe to be indifference, the medical men of this community have shown very little interest in the clinic's activities and, as a result, the children examined do not receive as much medical and surgical attention as their physical condition seems to call for. The special classes of this city are also not of the best type and, in consequence, directions for special or vocational training have had to be made very simple. Otherwise, placing the patient in the special class means little more than segregating him from the normal children during school hours.

Since the organization of this clinic, 173 cases have been examined in the section dealing with mental defectives. Of these, 77 have been referred by the school authorities, 4 by the detention home, 5 by the workers of the County Red Cross, 36 by relatives or guardians, 19 by orphan asylums, 8 by physicians, 9 by the county agent for the State Charities Aid Association, and 5 by the Public Health nurse.

Forty of these cases received the provisional diagnosis of moron, 36 that of imbecile, 1 of idiot, 5 of epileptic with no apparent mental defect, 1 of epileptic moron, 4 of epileptic imbecile, 2 of mongolian idiot, 1 of hydrocephalic imbecile, 2 of paralytic moron, and 1 of paralytic imbecile; 44 were diagnosed as backward as a result of physical causes, 7 as border line, 10 as having normal mentality, 1 as suffering from goitre, 2 from maladjustment, and 1 from chorea.

Of this group, 49 have been reinterviewed or reported on. Only 45 of this entire group had no marked physical defects. Of the remaining 128, 53 had enlarged tonsils and adenoids, 43 teeth in poor condition, 42 poor circulation, 7 enlarged cervical glands, 12 phimosis, 11 coryza, 5 pharyngitis, 1 spinal curvature, 28 Hutchinson's teeth, 1 umbilical hernia, 5 strabismus, 10 enlarged thyroid gland, 12 bronchitis, 9 defective sight, 3 otitis media, 1 corneal ulcer, 1 cataracts on both eyes, and 1 ulcerative stomatitis; 5 were undersized, 19 poorly developed and nourished, 5 anæmic, and 1 deaf.

The agencies referring these patients received recommendations for their treatment, and the following list will give some idea as to the most frequent recommendations made. Wassermann examinations were recommended in 49 cases, the removal of tonsils and adenoids in 42 cases; 39 needed dental work done, 14 glandular treatment, 8 improvement in their diet, 14 circumcision, 16 eye examinations, and 4 were in need of a great deal more fresh air. Vocational training was recommended for 31, and 28 needed the benefits of special-class work; 10 were advised to leave school and do farm or garden work; 9 needed an improved environment, and 2 better discipline; only 8 were recommended for institutional care.

The person who referred the patient for examination was always asked to state the special problem in the patient's case. Sixty-eight were referred for examination because they were retarded in school, 1 was a truant, 2 were underdeveloped, 1 was undersized, 8 "nervous," 7 had convulsions, 5 were slow or could not learn quickly, 2 had bad tempers, 10 were believed to be subnormal or defective, 1 was "different," 1 "not right," 1 "not normal," 1 "peculiar," 1 a masturbator, 1 inattentive, 1 paralyzed, 1 indecent, 5 did not talk, 1 would not work, 1 "could not do things," 2 were thieves, 1 "not safe to leave at home," 1 unteachable, 2 were disobedient, 4 were brought to the clinic to have their mentality investigated with the idea of adoption, 3 were "lazy," 1 with a bad family history was presented with the idea of determining his chances for a normal future, 2 were dull, 1 "not to be trusted," 2 were irritable, 1 had "peculiar spells," 2 were "ugly," 1 was "childish," 1 was "infantile," 1 could not learn to read, 1 had a poor memory, 1 was "stupid," 2 repeated grades, 5 had speech defect, 1 was "disturbed," 1 was dependent, 1 "made faces," 1 was "sullen," 1 over-active, 1 was presented by a mother who was curious to know the mentality of her child, and 1, a prostitute, was presented by a county agent, who wished to know "what could be done with the patient."

The second clinic was established simultaneously with a mental clinic organized by the State Hospital Commission. This clinic was first opened in the one hospital of a city of about 20,000. Owing to the inconvenient location of this hospital, the clinic was soon removed to the more conveniently located Red Cross Building. As there is no free dispensary or other clinic in connection with this location, patients are drawn from all stations in life as in the first clinic. This clinic was organized and ran for several months without newspaper publicity and, as a result, I am led to believe that we have gained more and better coöperation from the local physicians than in the other clinics. While perhaps there has not been a higher percentage of patients referred to this clinic by physicians, more medical men visit the clinic and show an interest in its activities.

After a session or so of this clinic, the local school authorities requested the examiner to spend one day of each month in the public schools. Permission for this having been received from the State Department of Education, the examiner has spent one day a month examining only school children presented by the supervisor of the special classes. Each of these children comes to the examination with a complete family and personal history secured by the school authorities. The personal history contains a detailed school and social history and is secured by the special-class teacher and the school nurse. Very frequently parents of these patients come to the clinics at the suggestion of the teachers, and recommendations for further care of their children are made in detail to them.

This clinic was opened in March 1920, and since then 129 cases have been interviewed. Fifty-four of these were presented by the school authorities, 49 by the local chapter of the Red Cross, 4 by physicians, 7 by the Associated Charities, 9 by relatives, and the others by the county agent for the State Charities Aid Association, the county Child Welfare board, the Public Health nurse, and the superintendent of the poor.

The problems in these cases were very similar to those mentioned in the previous clinic. Sixty-six of those examined were retarded in school, 1 was unteachable, 2 had convulsions, 1 was "dull," 1 did not grow, 1 was "wasteful," 3 had speech defect, 2 were of doubtful mentality, 1 did not progress properly, 1 was "irresponsible," 3 paralytic, 4 delinquent, 2 "lacked self-control," 5 were "peculiar," 1 was a truant, 2 were "nervous," 1 was "lazy," 1 "unusual," 2 had "peculiar spells," 1 was a thief, 1 was "slow," 1 did not talk, 1 was "suggestible," 2 were immoral, 2 were incorrigible, 1 was over-active, 1 was presented to the clinic for examination of mentality with the idea of adoption, 1 did not sleep at night, but slept in the daytime, 1 "had no ambition," 1 was "dirty," and 1 was "lawless."

The third clinic was added to a long-established state-hospital clinic in a city of about 100,000. The clinic is located in the city free dispensary, where free clinics of every known variety are already established and complete records of every case are kept. This arrangement is ideal for one type of case only, and that is the type that would visit a free dispensary for any other medical reason. It is quite unusual for an individual from any other social grade than the one just mentioned to come to the clinic for examination and these individuals rarely return after the first interview if they suspect that the dispensary keeps a record of the examination. For the type of patient that will accept charitable medical attention, the location of this clinic could not be improved, for patients in need of medical or surgical care or special laboratory examination are reported to the dispensary registrar, who sees to it that the treatment or examination recommended is provided.

One hundred and twenty-six cases have been referred to this clinic—37 by the schools, 5 by physicians, 32 by relatives, 20 by orphan asylums, 10 by the county agent for dependent children, 1 by the Humane Society, 4 by the children's court; several of the other local agencies interested in children have sent in an occasional child for diagnosis.

Of this group, 58 were examined because they were believed to be backward, 2 because they were thieves, 1 because he did not grow, 1 because he did not like school, 1 because he was "rebellious," and 1 man because he could do just one thing in the mill where he had worked for years; 1 would not work, 2 had bad tempers, 1 was incorrigible, 1 was a masturbator, 6 were immoral, 1 was "easily led," 1 was untidy, 1 ran away from home. Many other reasons similar to those already stated were given as reasons for the examination of other cases. The usual kinds of defect were found in these cases. One unusual one, not spoken of before, was a case of gigantism, which one of the charitable organizations presented because the patient was without a home and looked defective.

The fourth clinic has been established such a short time and so few cases have been examined that very little can be said about it except that it is located in the office of the city board of health and that there are several other free clinics in this same office.

This clinic was located rather hurriedly and the local physicians were not properly informed of the reasons for establishing it and the service it was hoped it would render to the community. After the clinic had been opened, it was found that, in the eyes of the local physicians, it was apparently a partisan of one group in a local medical disagreement, and it has been necessary to use a great deal of time and energy in the effort to get the physicians of this city to understand that the clinic is not interested in local medical differences, that no record of patients is kept at the clinic, and that the person referring the patient is the only one who receives a report of the examination.

Twenty-two cases have been examined in this clinic. These were presented by the usual agencies and the usual type of problems and conditions were encountered.

In brief, there have been 449 cases examined at the four mental clinics. Of these, 168 were presented by the school authorities, 75 by relatives, 29 by physicians, and 59 by workers from local chapters of the Red Cross. The others were presented by various children's agencies.

Of the entire number presented, 22 were found to be normal, 88 backward because of environmental or physical causes; 32 were diagnosed as border line, 84 as morons, 56 as imbeciles, 9 as idiots, and 19 as epileptics; 7 were believed to be maladjustments.

From the experience thus outlined, it appears that, when a clinic is to be established, some capable person who understands thoroughly the function of a mental clinic and who is able to give the local children's agencies and others a correct view of the problems of the mental defective and of the aims of the mental clinic should spend some time informing the groups interested of the plans of the contemplated clinic and its personnel.

If the clinic is to have but a one-day session, it should be located in some neutral place where there is no suggestion of charity and no free dispensary or other clinics, and where no local records of the patients examined are kept. If a session of more than the one day is to be held, at least one of these days should be spent in a neutral place such as has just been described.

From the number of patients examined and from the number of different agencies presenting patients, as well as from the small number of patients examined that have become state charges, it is evident that the mental clinic can be of great aid in dealing with the problem of the mental defective.

ABNORMAL PSYCHOLOGY

BARRINGTON GATES

I AM, they say, a darkling pool
Where huge and cunning lurks a fool
Childish and monstrous, untaught of time;
Still wallowing in primeval slime.
All powerful he with fang and claw
To fill his red capacious maw,
And not a thousand thousand years
Have eased his belly, stilled his fears,
But ever with dim, consuming fire
Swirl the slow eddies of desire
About his sprawling limbs, and lull
The torments of his brutish skull.
He is most merciless, lone and proud,
There in the scaly darkness bow'd,
And sleeps, and eats, and lusts, and cries,
And never lives, and never dies.

Nay, but above this stagnant night
The lovely highways of the light
Sweep on with winds and dawning flowers
And stoop to touch its midnight hours.
If I am he, I'm also one
With all that's brave beneath the sun,
With lovers' singing, and tall great trees,
And the white glory of morning seas.
What of this silence, so there stay
Child's laughter to the end of day?
And what of dark, if on the hill
Eve is a burning opal still?

Reprinted from the *London Mercury*, June, 1921.

ABSTRACTS

THE PROBLEM OF A PSYCHOPATHIC HOSPITAL CONNECTED WITH A REFORMATORY INSTITUTION. By Edith R. Spaulding, M.D. *Medical Record,* 99:815-21, May 14, 1921.

Ten years ago, when the state of Massachusetts made an appropriation for an institution for defective delinquents, it was generally supposed that all those persons who had been misfits in the various institutions to which they had been sent—mental hospitals, schools for the feebleminded, and reformatories—would be found to be defective intellectually as well as emotionally, and hence would be fit subjects for permanent segregation. A closer study of these individuals, however, revealed the fact that many of them ranked high in psychometric tests, and some doubts arose as to the legality of committing such persons, since, with all their irresponsibility and lack of emotional control, they were neither insane nor intellectually defective. Certain examiners agreed, therefore, that the term "defective delinquent," as used in diagnosis, should include only individuals who are intellectually defective as well as delinquent. This is, in Dr. Spaulding's opinion, the only accurate use of the term. Should it be applied to every case with a personality defect of some kind, it would include practically the entire reformatory population. Again, it is a misnomer and leads to misunderstanding and a confusion in diagnosis when it is applied to that heterogeneous group of individuals that constitute one of the most difficult of institution problems. Such individuals should be called preferably psychopathic delinquents, and they are the group with which a psychopathic hospital connected with a reformatory should concern itself. The present discussion is based upon an experience of over a year and a half with a group of this kind at the Psychopathic Hospital of the New York State Reformatory for Women at Bedford Hills.

The cases with which such a hospital has to deal include "borderline cases of mental disease, such as manic-depressive cases showing much instability, but not in an acute phase; early cases of schizophrenia and cases of cerebrospinal syphilis that are not committable; psychoneurotic and neurotic conditions; cases of epilepsy; and the many that may be grouped under the general terms of constitutional inferior or psychopathic personality and who are also subject to psychotic episodes. Since such a hospital must necessarily be, in so unchartered a field, a research laboratory, there should be included, with the cases showing obvious nervous and mental symptoms, all problematic cases with marked conduct irregularities. Many cases will remain in the hospital but a short time and can be returned to the institution proper after a period of observation, but the majority of cases will be the very difficult ones that, because of their emotional instability and unadaptable traits of personality, find it impossible to maintain their equilibrium for any length of time in the midst of the main institutional group."

The removal of these unruly individuals from its midst is a great help to the main institution, but the problem of managing them as a single family group is a difficult one for the psychopathic hospital. For eight months the attempt was made to manage the hospital at Bedford Hills like any psychopathic hospital unconnected with a reformatory. No punishment was used except an occasional locking of doors, and every effort was made to build up the patients physically and to help them to a more constructive attitude toward life. The result was constant unrest, friction, and dissatisfaction. To give an idea of the difficulties encountered, Dr. Spaulding describes in some detail a day at the hospital, with its series of emotional explosions beginning at six o'clock in the morning and ending only with bedtime.

Whether or not the treatment of such a group as this as mental cases might be successful under certain conditions, Dr. Spaulding does not attempt to decide. She simply shows what factors entered in to complicate the situation at Bedford Hills. In the first place, in any such group selected from the population of a disciplinary institution, there will always be certain individuals who will take advantage of the fact that no punishment or deprivation of privileges will follow an infringement of rules. They will instigate as much trouble as possible to test the system and will crow over the inmates of neighboring cottages who are under a stricter discipline. This is certain to have a disastrous effect upon the morale of the surrounding cottages.

Another difficulty is the attitude of suspicion and resentment on the part of the patients due to the fact that they are being treated as mental cases. Their knowledge that they are regarded as "nuts" by the other inmates of the institution seems to result in a determination to live up to their reputation, perhaps in an effort to compensate by recklessness and abandon for their half-conscious sense of inferiority to their more stable companions. They have, too, all the layman's usual dread of a hospital for mental disease, and the fact that it is often necessary to transfer cases to such a hospital deepens their distrust of the psychopathic hospital and makes it very difficult to maintain an atmosphere in which fear and suspicion do not predominate.

The presence of the workers in the hospital is another complicating factor. Although chosen from among the more stable of the reformatory girls, these workers are none too stable at best, and the effort to hold them to a higher standard of behavior than that required of the patients inevitably results in trouble.

As to the question whether discipline in any form is necessary in such an institution, Dr. Spaulding has this to say:

"We gave the experiment a trial and were not successful without it [discipline]. The friction was constant and the hospital morale sunk to its lowest level. . . .

"The question of what discipline is and how it may be administered is a subject on which volumes might be written. It is only possible to say here that we have found that a definite set of rules, correlated with a deprivation of privileges, administered always from a therapeutic point of view, even though by a layman, was very helpful in influencing the whole atmosphere of the hospital. There are undoubtedly cases in which exceptions must be made, but it is much easier to make exceptions in disciplinary measures in a few cases than it is to control the emotional reactions that occur in the psychopathic patients in general as a result of the license that follows when the disciplinary measures that are needed by the majority are suddenly withdrawn."

The article closes with the following general conclusions:

"Those who have dealt with a group such as I have described in the midst of a larger and, in itself, a difficult group of emotional, unstable persons, either in a hospital for the insane or in a reformatory institution, have realized for years the need of an institution where such patients could be segregated in order to promote the stability of the larger group and also to give to the few the amount of outlet and individual attention necessary. That there is such a need is obvious. But that it can be met by placing such individuals together, at least in a single group, is not yet proved. The problem, which will vary always with the individual members of the group at a given time, may not be solved for many years to come.

"The chief function of such a hospital connected with a reformatory institution should be to differentiate types. In the initial examination made of each woman on entrance to the institution, any cases needing immediate transfer to a mental hospital should be recognized before they join the general population of the institution and should be sent to the appropriate institutions without going through the psychopathic hospital. While this number is small, being in our experience but 2 in 100, it is of much importance. Cases doubtful in nature should be sent to the hospital for a period of observation. The majority of cases, however, that are recognized as being markedly unstable at entrance belong to the hospital throughout their entire residence in the reformatory. It is by removing the more unstable ones from the general population that the institution proper is given a chance to maintain a higher standard in morale and the psychopathic individuals themselves are given the best chance to maintain their highest level. The hospital should also be equipped to take for study and observation any patient who presents a special behavior problem in the institution proper.

"It is in the management and treatment of the resulting heterogeneous group that the real difficulty of the problem lies, because a fairly stable background is necessary as a foundation for reëducational procedure. The most important factor, then, consists in finding a social level into which they can best fit, so that as much effort as possible can be expended on their individual reconstruction. This reconstruction of personality should consist, generally speaking, in efforts to socialize their egotism. It should include any therapeutic measures that will benefit the physical condition of each woman, the stimulation of healthy interests and activities, and the unearthing of mental conflicts that have kept the personality from developing beyond infantile levels; and find ways to counteract feelings of inferiority, to sublimate primitive desires, and build up the weakest points in each personality, whatever they may be."

A PSYCHOLOGICAL STUDY OF SOME MENTAL DEFECTS IN THE NORMAL DULL ADOLESCENT. By L. Pierce Clark, M.D. *Medical Record*, 99:991-6, June 11, 1921.

For some years mental tests have revealed the existence, both in schools and in industrial life, of a large group of individuals who suffer from slight mental retardation, though they rank too high to be classed even among the border-line cases of feeblemindedness. Study of this group has thus far been mainly confined to the quantitative aspect of their mental defect. Practically no attempt has been made "to determine and classify the exact degree of qualitative mental disorder from which these individuals suffer." Yet in view of the fact that many delinquents and antisocial individuals are recruited from this group of so-called normal-dull persons, it is highly important that an effort be made to understand the psychology of their emotional life and "determine to what extent the state is remediable or adaptable to the end of good mental health."

In spite of the hopes of endocrinologists that glandular treatment may hold out the possibility of a cure for the milder forms of mental retardation, it is Dr. Clark's opinion that the best hope for the normal-dull person, as for the feebleminded, lies in "the old, well-proven procedure of education and better adaptation of the individual to his life purposes at the level of his innate capacity." This involves a consideration of character traits as well as of intellectual equipment. "The fault of many normal-dull persons is not simple mental deficiency. Indeed, the detection of this fault is a relatively simple task compared with an analysis of the psychopathic traits." Dr. Clark is inclined to believe that mental retardation plays less part than is generally supposed in the inducement or the encouragement of conduct disorders in normal-dull persons, and that their education should include character and conduct training instead of being directed solely toward the improvement of their intellectual standing. Psychologists, whose work in testing this normal-dull group Dr. Clark reviews briefly, have called attention to the fact that many of these individuals are very valuable members of society, better fitted to perform certain kinds of work than people of a superior intellectual endowment, who are likely to become discontented and restless at monotonous tasks.

"From an analysis of the whole subject, it would seem that the 'normal-dull person' is not feebleminded, but simply 'dull.' Being 'normal' as far as the emotional part of his nature is concerned, he will get on fairly well and may become a valuable member of society, provided he is in the right milieu. Lack of work and bad company may make a derelict of him and, sooner or later, land him in the workhouse or in jail. What the normal-dull person needs is some training which will enable him to make himself useful in one of the many occupations in which a certain mental inferiority, far from being a handicap, is in reality an advantage."

The simple mental testing that reveals the intellectual deficiency does not, however, as a general rule indicate the character defects or the emotional faults that may also be present. "In some respects," Dr. Clark states, "these conduct disorders, when present, are not dissimilar to those seen in the moron, although the pattern plan of the antisocial acts is obviously cleverer and more elaborate. The main difference in such acts of the normal-dull person and those of the psychopathic inferior is the presence in the former of a more enduring affect regarding the specific delinquency, and the field of delinquency does not spread over so large a field of activity. Then, too, the acts are more closely connected with the genetic instinct. In many it would seem as though the main first fault were not a disciplinary one, but the boy's unsuccessful repression of his too lively sexual fancy and desire. The general temperament of the normal-dull person is on the whole one of tender-mindedness rather than the callous indifference of the so-called psychopathic delinquent. In the composite, one would say the antisocial act of the normal-dull person is analogous to the heedless carelessness of the moron combined with a sexual tinge of the socially unstable plus the narrow transgressions of the petty offenses of the psychopathic delinquent."

Two case histories are given as illustrations, both cases of adolescent boys in whom a slight mental retardation was associated with more or less serious character defects. Their significance lies in the fact that they undoubtedly represent a very numerous class among adolescents. From several years of study of such cases, Dr. Clark draws the following conclusions: (1) that "there are early evidences of primary faults in the instinctive life of these youths" and that their character defects are almost invariably exhibited in the ascendants; (2) that "the character faults would seem to be on the whole independent of the quantitative estimation of mental defect, although the two are frequently correlated and a greater number of delinquents would probably be found in this group than in the normal group;" and (3) that "there is a great need for schools, both private and public, to recognize the qualitative faults in such individuals and establish an education adapted to overcoming the same," quite independent of the effort to correct the mental retardation.

"A general pedagogical and training approach to this complex problem of the dull-normal person is the immediate practical question, both in the field of his concrete-mindedness and the training out of the character faults which are likely to occur far more frequently in this group than in the general run of abnormal adolescents. To prevent or train the dull-normal adolescent we have need of the very best in pedagogic psychology. . . . Every child is more or less interested equally in adventure and fairy tales. Their colorful and vivid appeal is for all. Why is it not possible so to ingraft the simple, natural, and appealing principles of symbolic thinking of childhood into ways of thinking upon school studies? Thus we may carry the concrete principles of work of the grammar school into the high school and college curriculum. In point of fact, that is what is actually done with these dull-normal, concrete-minded pupils when they are sent as educational problems to the cleverly arranged preparatory school. First of all, the teaching personnel must be capable of diffusing its own vivid human interest in the subject to the slow-footed, plodding student—a sort of benevolent contagion of thinking is imparted. Then, too, the teacher should constantly add the vividness of concrete application to the symbolic thinking as he advances his subject. Teachers in all walks of life are too apt to consider illustrations as digressions and time-killers, and use them sparingly. If they but realized it, the intellectual things which they wish to teach their auditors should have a warp of concrete presentation with a woof of symbolic thinking instead of vice versa; the dull-normal student would then stand a better show of getting on."

THE SOCIAL WORKER'S APPROACH TO THE FAMILY OF THE SYPHILITIC. By Maida H. Solomon. *Hospital Social Service,* 3:442-52, June, 1921.

In the main, the social worker in syphilis need be no different from any good social worker. She should possess mental poise, sympathy, tact, and judgment. She must be interested in the medical as well as the social side of the problem. Syphilis is a contagious disease and should not be looked upon as a punishment for sin. The moralist point of view should be avoided. The social worker must enter the lives of her patient as a human being, treating each family according to its individual needs.

In summarizing, the author states that the social worker's duties are:

1. To instruct the family how to avoid infection, emphasizing the seriousness of the situation, but avoiding over-frightening the family.
2. To find out whether any other members of the family are infected, by arranging for family examination.
3. To aid the patient in disclosing the fact of syphilis in such a way that the mate acquires the right attitude.
4. To utilize the mate as an ally in making the patient take continuous treatment.
5. To arrange for treatment of syphilitic relatives, and to see that it is carried through by endeavoring to develop a coöperative spirit, especially in the difficult problems of seemingly well relatives and syphilitic children.
6. To secure family examination for early symptom-free syphilitics and late syphilitics, recognizing that this is more difficult to bring about than the examination of the family of contagious patients.

Some of the more pressing situations one must be prepared to deal with are:

1. Readjustment of the mental life of the family.
2. Readjustment of the physical life of the family.
3. Economic difficulties in the families of late syphilitics, including such situations as a working wife, diminished income, charitable aids, etc.

One cannot offer any method of dealing with these situations. It is important for the worker to analyze the effect of her methods in each case, to plan new attacks, and to synthesize her successes and failures into a better technique.

SOME PRACTICAL POINTS IN THE ORGANIZATION OF TREATMENT OF SYPHILIS IN A STATE HOSPITAL. By Aaron J. Rosanoff, M.D. *State Hospital Quarterly,* 6:319-24, May, 1921.

It is now recognized on all sides that it is incumbent upon every state hospital to provide efficient organization of personnel, equipment, and procedure for the treatment of syphilis.

In an effort to develop such an organization in the Kings Park (New York) State Hospital, some practical points arose for consideration. Not a little correspondence, discussion, investigation, and experimentation were necessary before a definite policy and technique were adopted. Some of the questions that came up are discussed in the present paper.

The cases of syphilis that are met with among state-hospital admissions may be classified as follows:

Systemic syphilis { latent
  active

Neurosyphilis { mesoblastic ("cerebral syphilis")
  parenchymatous ("general paralysis")

As regards latent systemic syphilis, the main point is that it can be brought to light only by means of routine Wassermann tests practiced in all cases admitted to the hospital. There is, as a rule, no etiological connection between the syphilis and the mental disorder in such cases. These patients should, however, receive antisyphilitic treatment on general principles, and, in event of parole, provision should be made for the continuance of such treatment extramurally.

Cases of active systemic syphilis, it need hardly be said, are in even more urgent need of prompt, vigorous, and persevering treatment, although in such cases, too, there is no etiological connection between the syphilis and the mental disorder.

As to neurosyphilis, the most significant of the recently discovered facts with regard to cases of mesoblastic invasion are (1) that such invasion occurs in a high percentage of cases early in the course of the infection—namely, in the primary and secondary stages; and (2) that it may exist without giving rise to nervous or mental symptoms, or may manifest itself by slight, vague, or transient symptoms, so that there is danger of its being overlooked.

The practical bearing of these facts is that all cases of systemic syphilis, latent or active, should be, at some time in the course of their treatment, investigated by lumbar puncture, in order to dispose of the question of possible invasion of the central nervous system; and that no case of syphilis can be discharged as cured until not only the clinical and blood-serum findings have been rendered persistently negative, but also the spinal-fluid findings.

Finally, in regard to neurosyphilis caused by parenchymatous invasion—i. e., general paralysis—the question is asked: Considering all past experience, which is discouraging, should such cases receive antisyphilitic treatment at all? In the author's opinion the answer should be in the affirmative.

There has been much discussion as to the choice between arsphenamine and neo-arsphenamine. The question presents for consideration three distinct elements: (1) trypanocidal power, (2) toxicity, and (3) convenience in administration.

Experimental investigations recently made by Schamberg and his associates in the Dermatological Research Laboratories of Philadelphia have shown that arsphenamine is 1¾ times more curative than neo-arsphenamine, but is at the same time 2½ times more toxic. Accordingly, it is possible to choose for neo-arsphenamine such dosage as to secure greater curative and less toxic effect than by means of arsphenamine.

The paper includes an outline of the technique of administering neo-arsphenamine.

THE MENTAL CLINIC AND THE COMMUNITY. By Everett S. Elwood. *State Hospital Quarterly*, 6:381-84, May, 1921.

The establishment of out-patient work at the hospitals, including the clinics and the after-care work—or, as it is sometimes called, social service—has accomplished much in bringing about a closer relation between the state hospitals and their individual communities, and a better appreciation by the public of the true nature of the hospitals for mental disease and the splendid work they are doing. The establishment of after-care work at the Manhattan State Hospital was the first definite move in this direction, and this was followed rapidly by the establishment of free clinics for mental cases in New York City. This work has grown so that the state hospitals now have a total of 23 social workers and 41 clinics. As the people become more and more acquainted with the work of the state hospitals, and as they are given opportunity of seeing mild types of mental disease get on very well in their own communities, their prejudice and superstition against all forms of insanity gradually disappear.

The work of the mental clinics is greatly appreciated by most of the communities in which they function. During the past year, requests have been received from several cities for the establishment of clinics under the guidance of state-hospital physicians. Such a clinic was recently organized at Glens Falls at the request of the health officer. The dean of a prominent medical college recently wrote and asked what he could do to facilitate the organization of this good work in his city. Public-school departments are particularly anxious to receive the help that clinics afford in the diagnosis and treatment of border-line cases developing among school children.

The future is very encouraging so far as the work of the mental clinics is concerned. The time is probably not far distant when each state hospital will have to have an extra physician on its staff to attend to this field work, for the assignments of duties within the institutions are in most instances sufficient to demand the whole time and energy of the medical staff.

Such a service to the community should have the adequate support, not only of the state hospitals themselves and the various social forces in the different communities, but also of the appropriating authorities of the state. It is not only a saving in dollars and cents to keep a patient sufficiently balanced to forego the necessity of hospital commitment, but it is a great saving in the welfare and happiness of the individual patient and his family.

AN ANALYSIS OF SUICIDAL ATTEMPTS. By Lawson G. Lowrey, M.D. *The Journal of Nervous and Mental Disease,* 52:475-481, December, 1920.

In view of the lack of accurate statistics on the causes of attempts at suicide and the mental states of those who make them, the Boston Psychopathic Hospital undertook an investigation of the cases of attempted suicide among its admissions for a period of about six months, obtaining sufficient data on 46 cases to permit of an analysis, including a diagnosis of the patient's mental condition, the reason or reasons for the attempt, and the method selected. In this paper Dr. Lowrey, chief medical officer of the hospital, gives a brief history of each of these 46 cases and summarizes the results.

The diagnoses were as follows: dementia praecox 16, manic-depressive 9, psychopathic personality 5, psychoneurosis 3, paranoid condition 2, alcoholic 2, epileptic 3, undiagnosed psychosis 2, depression with paralysis agitans 1, cerebro-spinal syphilis 1, senile psychosis with depression 1, arteriosclerotic psychosis 1. The high proportion of dementia-praecox cases as compared with the manic-depressive was unexpected, but may be partly explained by the fact that the hospital receives about 3 times as many of the former as of the latter. "It is evident, however," Dr. Lowrey states, "that we must guard against suicidal attempts in dementia praecox more than we had thought necessary."

Depression, though the most frequent immediate cause, was responsible in only about one-third of the cases (14). In 7, the attempt was directed by hallucinations or delusions; in 6, it was an effort to escape imaginary persecutions; in 5, it was the result of discouragement over physical disease; in another 5, a method of gaining sympathy and attention; 3 patients made the attempt in a confused period following an epileptic seizure; 1 was trying to escape from a love tangle and 1 from insanity with which she believed herself to be threatened. The remaining 4 would give no explanation.

The methods used were: cutting in 17 cases, gas in 13, poison in 8, drowning in 6, hanging in 4, jumping from a window in 3, swallowing foreign bodies in 2, strangulation in 1, shooting in 1, and setting fire to the clothing in 1. The total of attempted methods comes to more than 46, as several of the patients had tried more than one method. The predominance of cutting and gas are probably due to the fact that sharp instruments and gas are the tools most easily obtainable.

Touching upon the much discussed question whether a normal person ever attempts suicide, Dr. Lowrey is of the opinion that there are many conceivable situations in which a normal person might choose death as the lesser of two evils, but that the burden of proof in any individual case rests with those who claim normality for the suicide. All of the persons in the series under discussion were in an abnormal mental condition at the time of the attempt.

BOOK REVIEWS

PSYCHOPATHOLOGY. By Edward J. Kempf, M.D. St. Louis: C. V. Mosby Company, 1920. 762 p.

Kempf's book divides itself readily into a theoretical and a clinical part, and it is the reviewer's hope that the stupendous task of doing justice in a brief review to this truly epoch-making book may be lightened by adhering to this division.

In doing so one may unhesitatingly say that in the presentation of his clinical materials Kempf has rendered a lasting and a quite unprecedented service to psychiatry; this notwithstanding the fact that the interpretation of this wonderful collection of data—clinical and other—will probably remain for a long time a matter of individual psychiatric preference. This is as it should be, and Kempf himself will undoubtedly be the first one to welcome constructive criticism on the question of interpreting his material.

The reviewer has no settled opinion on the subject, but finds himself, after a perusal of these interesting and very fully recorded case histories, with a greater respect than ever before for those thoroughly substantial guiding lines that above all else characterize American psychiatry and that are embraced in the dictum so frequently enunciated by Meyer—namely, that we are to seek in the patient and in his difficulties the explanation of his problem as well as the key to its solution. Kempf must be rated as one of the most distinguished of Meyer's students, and it is not to be suspected that he has deviated from this principle very much.

As for the theoretical side of the book, it is not necessary to restate here fully Kempf's formulations. In the present volume, he has at times condemned, at other times elaborated, the theories pretty fully presented in his monograph on *The Autonomic Functions and the Personality.*[1] Briefly stated, his theory is that it is the autonomic apparatus that dominates the personality, and that psychopathologic manifestations indicate the manner in which the ego manages the demands made upon it by cravings of the autonomic segments. The central point in the theory, as originally stated by Kempf, is "that in the higher organisms an affective sensorimotor system (autonomic) exists which created and uses the cerebrospinal or projicient sensorimotor system as a means to keep in contact with the environment in order that the autonomic apparatus may fulfill its biological career."

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[1] For a review of this by Dr. L. Pierce Clark, see MENTAL HYGIENE, Vol. 4, 251-52, January, 1920.

It seems to the reviewer that in the present volume by far the most interesting and valuable discussion is that relating to the question of the conditioning influence of life experiences upon the working of the personality, a phase of Kempf's contribution concerning which definite opinion may be formed quite apart from what one's attitude might be towards the more central of Kempf's theories.

Highly interesting also is his handling of the problem of consciousness and his classificatory scheme of psychopathologic reactions.

In closing this unpardonably fragmentary statement of Kempf's contribution, the reviewer desires to express the conviction that no psychiatrist can afford to remain unfamiliar with the contributions of this writer.

BERNARD GLUECK.

New York School of Social Work.

THE UNCONSCIOUS: The Fundamentals of Human Personality, Normal and Abnormal. By Morton Prince, M.D., LL.D. Second edition, revised. New York: The Macmillan Company, 1921. 654 p.

To the first edition of this work have been added Lecture XVII (*The Structure and Dynamic Elements of Human Personality*) and Lectures XVIII-XX (*The Psychogenesis of Multiple Personality—The Case of B. C. A*).

This work of Dr. Prince comprises a series of lectures designed as a course in psychology for medical students, to precede the courses in psychiatry and neurology. Such a course is highly desirable, and it is about time that the medical schools should appreciate its necessity, based upon the fact that there can be no adequate dealing with the sick individual as patient that does not take into consideration his personality make-up and arrange therapeutic devices accordingly.

As to the matter of the lectures: In the first place, the term unconscious seems to the reviewer to be used in a rather confusing, not to say unfortunate, sense, despite the author's efforts to define it clearly. He uses the term subconscious generically to include what he terms the co-conscious—or "actual subconscious ideas which do not enter the content of conscious awareness"—and the unconscious, or "neural dispositions and processes" (p. x). Co-conscious phenomena are those long ago made familiar by the work of Janet, by the author in his excellent case reports, and by many others, and include the familiar phenomena of dissociated mental states, multiple personality, etc.

What is included in his concept of the unconscious, however, is somewhat more difficult to understand. He uses the term "to characterize that which is devoid of the attributes of consciousness" (p. 249). While the reviewer agrees with the author that it smacks of quibbling to object to the term "unconscious ideas" as involving a contradiction in terms, "as we know well enough that the adjective is used in the sense of unawareness" (p. 250, footnote), still to speak of the unconscious in one place as "that which is devoid of the attributes of consciousness" (p. 249) and in another as "neural dispositions and processes" leaves the reader quite confused, especially as the author also uses the term "physiological memory" (p. 229) and so seems definitely to confuse two disciplines, physiology and psychology. This confusion of physiology and psychology is still more apparent when, in speaking of the education of a decerebrate dog, he says: "New dispositions and new connections may be acquired within the lower centers without the intervention of the integrating influence of the cortex or *conscious intelligence*" (p. 238).[1] Does he mean here the cortex or the conscious intelligence, or does he mean that cortex and conscious intelligence are interchangeable terms? If the latter, then the implication is that the cortex is a single organ with the function intelligence. Surely an indefensible position.

The interchange of physiological and psychological terms is a common source of confusion. There is no objection to analogies and figures of speech, but the two should be kept separate in thought. The unconscious as neural process has no place in psychology; it is plainly a problem for physiology.

The book, as a whole, impresses the reviewer as a development and elaboration in detail of such work as that of Janet and McDougall. As the work of Janet dealt for the most part with those phenomena which Prince calls co-conscious, so it seems to the reviewer that this is the material which is principally elaborated throughout the book. It is a long way from co-conscious to neural process, and this region is quite inadequately handled. There is no suggestion as to how the psychological simples of early infancy play their part in the complex elaborations of the adult. This is the region of the Freudian unconscious, repressions, and fixations, and although Dr. Prince is not a Freudian, he might have given these views more consideration than he has. To ignore them almost altogether is to leave a great hiatus in the account of the personality.

The lectures, as a whole, are well devised to serve the purpose for which they were intended. They make a book that is readable, illuminating, full of information gleaned from clinical experience, and withal a credit to American psychology. Would that every medical student could have the privilege of so excellent a course!

WILLIAM A. WHITE.

St. Elizabeths Hospital.

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[1] Italics not in original.

A GENERAL INTRODUCTION TO PSYCHOANALYSIS. By Sigmund Freud. New York: Boni & Liveright, 1920. 406 p.

Were one interested here primarily in the presentation of Freud's views and doctrines, this review could be made very brief, as indeed the review of any of Freud's original writings can afford to be. Freud's teachings have achieved such an astounding degree of popularity and enjoy such wide discussion that it is but necessary to note the appearance of a new book on Freudian psychology to assure for it wide attention.

The reviewer's task in connection with publications in this field has come to be chiefly a task of searching for something new in these contributions and, unfortunately, of pointing out that for which claim is made, for novelty often enough proves to be more novel than dependable. It is for this, if for no other reason, that the serious student of psychology ought to feel grateful to Professor Freud for having again restated his original views.

The book ought to serve as a dependable standard by which to measure the validity of the various outpourings on Freudian psychology that have achieved such singular popularity, especially in this country. Such a comparison will bring into bold relief first of all Freud's refreshing conservatism and moderation as compared with the unbridled enthusiasms of some of the exponents of his teachings. While the latter do not hesitate to assure us with noisy conviction that psychoanalysis is the cure for all human ills and evils, Freud, after over a quarter of a century of diligent research, and after a very rich clinical experience, is still inclined to restrict its usefulness to the functional nervous disorders.

The translation has been executed in the main carefully, although in spots it is rather crude and occasionally somewhat misleading, as, for instance, when the word "delusion" is translated into "obsession." The book comprises the material of twenty-eight lecturers intended to cover the main outlines of the Freudian psychology. It should not only be of interest to those who wish to make a first acquaintance with Freud's contributions, but through its clear and dependable restatement of fundamental principles, it should prove very valuable even to the specialist in this field.

BERNARD GLUECK.

New York School of Social Work.

SLEEPWALKING AND MOON WALKING; A Medico-literary Study. By Dr. J. Sadger, of Vienna. Translated by Louise Brink. New York and Washington: Nervous and Mental Disease Publishing Company, 1920. (Monograph No. 31.) 140 p.

In this work the author takes up the problem of noctambulism and the relation of light, especially the light of the moon, to the phenomenon. He begins with the analysis of a case which he treated for nine months on account of severe hysterical symptoms. After this period of treatment, the patient volunteered to write an autobiography, and the author rather naïvely assumes that there is very little of his influence to be seen in her explanations and interpretations. As is to be expected from the author, the sleepwalking is explained as the expression of definite infantile desires of a sexual nature. The influence of the moon was largely due to the sexual associations of this heavenly body.

The author makes quite unwarranted statements about the psychology of childhood. According to him, "children, when they see the full moon, or their attention is called to it, begin to snigger. Every one familiar with the child psyche knows that such giggling is based on sexual meaning, because the little ones usually think of the nates."

For the author the sleepwalker climbs up on the roofs as a fulfillment of a childish wish to climb up into the very moon. In the rest of the clinical section the author reviews briefly a few other cases; the reader meets a number of gratuitous assumptions, but, at the same time, sees signs of grace in the statement: "It must be admitted, to be sure, that we have to confine ourselves to mere conjectures." This admission contrasts, however, with the "doubtless" of the preceding sentence (p. 42).

In the second part numerous examples of literary work in which sleepwalking plays a part are subjected to analysis or rather to sexual interpretation. The author's facility of hypothesis is here also illustrated; where data are wanting, they are merely assumed. Thus the death of the mother of the heroine of the novel *Maria* occurs at some unknown date—"We do not discover when she died nor how old the little one was when she lost her natural protectress" (p. 73). On the following page, we find: "Yet I am of the opinion that she had already in her seventh year begun to play this rôle—in which year the death of her mother would be placed."

The author takes up the sleepwalking of Lady Macbeth, and explains to us, not only why she was so ambitious, but also why she carried a candle in her sleepwalking. The marital relations of the noble pair are also revealed. The fact that she remarks, "To bed," and other minor indications, show unmistakable sexual implications. The fact that she repeats a word several times is infantile. Lady Macbeth is dominated by a father-complex, and in the sleepwalking she partly identifies herself with her father. Her ambition reveals the fact that she was a bed-wetter in childhood. It is true that Holinshed in his *Chronicles* gives no data to confirm this. To the reader the bed-wetting of Lady Macbeth is presented as a fact beyond dispute.

It is not necessary to go into the detailed relations of her father and mother, which are presented with equal assurance and naïveté. To the translator this is "a profoundly suggestive study of the psychic background of Shakespeare's creative work as illustrated in the sleepwalking of Lady Macbeth." To the reviewer it is a typical example of the dogmatic presentation of a mixture of fact and hypothesis which does more than anything else to discredit many recent advances in psychopathology.

C. Macfie Campbell.

Boston Psychopathic Hospital.

Ten Sex Talks to Boys: Ten Years and Older. By Dr. Irving David Steinhardt. With an Introduction by Ernest Thompson Seton, Chief Scout, Boy Scouts of America. Philadelphia and London: J. B. Lippincott Company. 187 p.

Ten Sex Talks to Girls: Fourteen Years and Older. By Dr. Irving Davis Steinhardt. With an Introduction by Rachelle S. Yarros, M.D., Chairman of the Social Hygiene Committee of the American Federation of Women's Clubs. Philadelphia and London: J. B. Lippincott Company. 193 p.

Thousands of boys throughout the country, enrolled in that excellent organization, the Boy Scouts of America, look to their Chief Scout with great respect and admiration. The parents of these same boys look to him in confidence for advice on many troublesome problems, and one of the chief of these, no doubt, is the problem of sex instruction. A book on this subject, therefore, that has an endorsement, through an Introduction, by Mr. Seton becomes an important book regardless of its own merits. The same may be said of any book of "sex talks" to girls that has an Introduction by the Chairman of the Social Hygiene Committee of the American Federation of Women's Clubs. ,To the chairman of this committee mothers in all parts of the country naturally turn with confidence for advice in such puzzling matters as sex instruction for their daughters.

A reviewer, likewise, turns to these books with confidence. A book is not likely to be recommended to the Boy Scouts of America, it is assumed, by the Chief Scout, or to the mothers of the American Federation of Women's Clubs by the chairman of an important committee, unless it be carefully written and free from the misstatements and gross exaggerations that have done incalculable harm in other books of the kind. But—one can scarcely believe it—here is the same vicious specter of the past generation that must now be paraded before the Boy Scouts of America and the daughters of the American Federation of Women's Clubs:

"I have seen boys as young as twelve years, or slightly more, and upwards, in insane asylums from excesses of this kind [masturbation] and the cure of the mental condition, in these cases, is almost hopeless. . . . " "The forms of insanity most often produced by excessive masturbation and excessive sexual indulgence are melancholia and acute mania, excessive masturbators being usually afflicted with melancholia, a most distressing form of insanity . . . about as near a living death as anything can be." "Masturbation, if indulged in to excess, will cause a breakdown of the nervous system, and cause you to end your days in a madhouse, or send you to an early grave."

If masturbation causes insanity, the cases are so rare as to be negligible; the fear of such a possibility, however, engendered by statements such as those quoted in the sensitive, repressed child, robbing him of confidence, courage, and self-respect, all fundamental elements in a healthy-minded, efficient person, and filling him with a sense of sin and guilt, the psychiatrist knows only too well. The very thing which the writer of these books and others would seem to wish to prevent—nervous and mental disease; or, after all, is it their main interest?—is the very thing which they tend to create by their false teaching. The patient who is insane as a result of masturbation exists in the minds of those who write these books; the patients who are distraught and made ill by this teaching are, however, a grave reality.

It is unfortunate that the author has allowed himself to hand on to the present generation this misinformation of his own generation and thus spoil what in many other respects are excellent books that would be helpful to parents, teachers, and others who appreciate the need for the teaching of sex hygiene to children and adolescents, but who are hampered in undertaking it by personal resistances and ignorance of subject matter and of method.

Most of us agree that the presentation of sex-hygiene material should be simple, straightforward, accurate, without sentimentality, and with sufficient detail to satisfy curiosity and discourage morbid, wondering rumination. These books certainly meet many of the above conditions; they contain much excellent, practical advise, as well as many appeals to the idealism of the adolescent. On the other hand, it is our belief that the subject matter as here presented will be more useful in the hands of adults than if given out to youths of either sex, since it is reasonable to believe that boys and girls in their early adolescent period will in many cases have curiosity aroused by allusions to things against which the author seeks to warn them, and that they will be much more interested in that sort of thing than in the presentation of anatomical and physiological facts which are frequently couched in terms too technical to be grasped by the average twelve- and fourteen-year-old.

Compared with the stress laid on the physical, the emotional aspect of the subject is neglected, such things, for example, as the rumination of children and youths along sex lines being disregarded or dismissed with arbitrary "Don'ts." Although the concrete material which the author presents so fully and ably is the foundation of sex instruction, mental-hygienists know that the more subtle or emotional side must not be overlooked if this teaching is to realize all its possibilities.

ANNE T. BINGHAM.
Mental Clinic, New York Probation and Protective Association.

FROM THE UNCONSCIOUS TO THE CONSCIOUS. By Dr. Gustave Geley. New York and London: Harper and Brothers, 1920. 326 p.

Another one of the many books which the modern interest in matters psychological has called forth and which seem to occupy a sort of border-land position between scientific and popular literature, belonging, perhaps, more particularly in the realm of mysticism than anywhere else. Like many such books, it shows the author to be widely read in all sorts of directions and to be well acquainted with a considerable scientific literature bearing upon his subject, but the reviewer must confess to approaching his task with a considerable prejudice when, on turning to the appendix, he discovered photographs of numerous materializations, spirit forms, conjured into being by some medium and snapped by the camera man on a stereoscopic plate. Some of the pictures are very much like, if they are not actual reproductions of, pictures in a work on materialization recently published which has been pretty thoroughly criticized from all directions. It is difficult for the reviewer to understand how such phenomena can gain serious consideration from the scientific mind.

When, in addition to the above, we note that the book endeavors to fill the gap between the conscious and the unconscious, "which has baffled so many eminent metaphysicists," we are suspicious. And, when, further, we learn that the author not only explains hypnotism and normal and abnormal personalities, etc., but extends his explanations to spiritism, and when we find from the appendix, as above mentioned, that the photographing of materializations is one of his methods of research, and from the text that telepathy is accepted, why, then all the author's learning and all his knowledge of literature, no matter how scientific, fails to counteract the prejudice of the reviewer before mentioned, and he feels that the author's learning has been sidetracked and used to prove the existence of pseudo-scientific phantoms. The usual arguments for spiritistic and mediumistic phenomena are made. They are to the effect that we should preserve an open mind and examine the evidence without prejudice. The evidence has been so frequently examined and it is so absolutely unconvincing and petty, and most of it so easily explained upon much less complicated a hypothesis, that it seems useless to repeat the process. Whatever was of suggestive value in the book has, in the reviewer's opinion, been ruined in its usefulness by an association with such unscientific positions and by a metaphysical, not to say mystical, style of presentation.

WILLIAM A. WHITE.

Saint Elizabeths Hospital.

SUGGESTION AND AUTO-SUGGESTION. A Psychological and Pedagogical Study Based upon Investigations Made by Charles Baudouin, Professor at the Jean Jacques Rousseau Institute, Geneva. Translated from the French by Eden and Cedar Paul. New York: Dodd, Mead, and Company, 1921. 349 p.

Baudouin has written a very interesting, though quite unnecessarily circumstantial account of suggestive therapy as practiced by M. Coué of Nancy. If the book is misleading because of the continuous reference to the "New Nancy School," when as a matter of fact the "school" in question consists wholly of M. Coué, a lay psychotherapist of Nancy, it is nevertheless very illuminating in its discussion of the theoretical formulations that are supposed to have grown out of the experiences of M. Coué. These formulations are stated quite fully by the translators in their preface as follows:

1. "The main factor in hypnotic phenomena is not hetero-suggestion, but auto-suggestion; and, as corollary, the chief advantages of psychotherapeutics can be secured without a suggestor and without the more salient factors of the hypnotic state.

2. "Of fundamental importance to success is what Coué terms 'the law of reversed effort'—the law that so long as the imagination is adverse, so long as a counter-suggestion is at work, the effort of the conscious will act by contraries. We must think rightly, or rather must imagine rightly, before we can will rightly. In a word, our formula must not be 'who wills can,' but 'who thinks can, or who imagines can.'

3. "The most significant phenomena of suggestion occur in the domain of the subconscious (unconscious). The new powers which auto-suggestion offers to mankind are based upon the acquirement of

a reflective control of the operations of the subconscious. Herein, as Baudouin shows in his preface and his conclusion, the teachings of the New Nancy School at once confirm and supplement the data of psychoanalysis.''

Throughout the book, the author labors to convince the reader of the close kinship between Coué's method and psychoanalytic practice, but actual observation of this method (the reviewer had an opportunity to make this) disclose nothing very startling new, nor is any attempt made in this procedure at a psychological understanding of the individual patient, psychoanalytic or otherwise. This has nothing to do with the fact that Coué possesses an extraordinarily keen insight into human nature, and actually achieves what at times might be termed marvelous therapeutic results. While the book stresses the element of auto-suggestion, the actual practice is not free from a strong element of hetero-suggestion, sometimes in a distinctly hypnoidal state.

In spite of the keen disappointment experienced in the attempt to match the actual performance with the very interesting description of it by Baudouin, the reviewer cannot help feeling that the method, as modified by Coué, has elements of much therapeutic value, especially in helping to solve the practical needs of a very busy psychotherapeutic dispensary. It remains to be seen whether any of the ''legitimate'' American psychotherapeutists will have the courage, in adopting Coué's method, to practice openly and deliberately what they are actually practicing under the guise of something else.

BERNARD GLUECK.

New York School of Social Work.

PSYCHOLOGY AND PSYCHOTHERAPY. By William Brown, M.A., M.D., D.Sc. With a foreword by W. A. Turner, C.B., M.D. New York: Longmans, Green and Company; London: Edward Arnold, 1921. 196 p.

In the introductory part of this book the author discusses a number of important topics in a very summary way and in a rather schematic manner. In the first two chapters special emphasis is laid upon dissociation, and brief statements are made with regard to the views of Janet, Freud, and Jung, without any detailed discussion of the issues involved. Terms such as neurasthenia and psychasthenia are defined in a rather rigid way, and in rather formal psychological terms, which seem somewhat remote from the concrete data of the clinic.

In the second part of the book the author gives a summary statement of Freud's theory of dreams and of the unconscious, and then passes over to discuss theories of emotion.

The third part is devoted to psychotherapy. Here the author lays stress upon the growing insight of the patient into his own mental condition (auto-gnosis) which is brought about by medical analysis. The psychoneuroses of war are discussed with illustrative examples, while the last chapter is devoted to somewhat abstract and unproductive discussions on the relation of mind to brain.

For the worker who is not familiar with psychopathology the book is probably too summary in its treatment, but it may be of value in presenting, in a condensed form, many of the leading issues.

C. MACFIE CAMPBELL.

Boston Psychopathic Hospital.

OUR SOCIAL HERITAGE. By Graham Wallas. New Haven: Yale University Press, 1921. 291 p.

This book needs no recommendation to those who know the scholarship and penetrating insight of Graham Wallas. Not so distinguished a piece of work as his *The Great Society*, it is, nevertheless, a trenchant exposition of a problem whose main outlines are suggested and argued without pretence of exhaustive consideration. The author's clear analysis and admirable illustrative material cannot be adequately indicated by a brief resumé of his thesis.

Social heritage he defines as that part of our nurture consisting of the knowledge of expedients and habits that were originally the personal acquisition of individuals, but that have been afterwards handed down from one generation to another by the process of teaching and learning. Man is becoming biologically more fitted to live with the help of accumulating arts and sciences, and less fitted to live without them. This contention, however, does not involve any Lamarckian assumption, but merely implies that those families which were more able to acquire and perpetuate social heritage would tend to survive and those parts of the nervous structure which the existence of social heritage rendered less necessary for survival would tend to degenerate. "Each generation, if it is to live happily and harmoniously, or even is to avoid acute suffering, must adapt to its present needs the social heritage which it receives from the preceding generation.

"The exhaustion of an old source of supply of food or raw materials, the appearance of a new disease, or an increase of population, may, of itself, make obsolete old arts and sciences and customs, and make new discoveries necessary. A new discovery . . . may compel the readjustment of tradition in a hundred ways."

The discussion is restricted to an inventory of the social heritage concerned in our organizations, political, economic, governmental, and religious.

The power of making sustained, conscious muscular and mental effort is not biologically inherited by man, but is acquired, the author contends. The scientific psychologist might take issue with him here, but Professor Wallas' amplification of the hypothesis arrests the attention. The change from intermittent to continuous effort was necessary for man to attain civilization, and he was obliged to invent methods of compensating for the resulting nervous strain or fatigue. Thus he learned to avail himself of the "drive" of artistic impulse and of the help of logical methods to increase efficiency.

Human conduct does not seem fully amenable to study by these rigid methods as do the physical sciences; therefore other technique, such as the Freudian psychiatry, has developed and various educational systems have been tried, resulting in the recognition of the need of more conscious intellectual effort in directing our activities.

In his chapter on group coöperation, Professor Wallas shows that it depends on a combination of socially inherited expedients as well as on the biologically inherited gregarious instinct. The former factors of discipline and discussion seldom yet prevail, but are ultimately eliminated by the clamorous primitive impulses to lead and to follow, as, for example, even in the British cabinet experts succumbed to the domination of Lord Kitchener against their own expressed emotional and intellectual inclinations regarding the Dardanelles decision.

Coöperation among members of a large group such as a nation is more dependent on social heritage. To create a trustworthy idea of the nation and play a part in its coöperation, it is necessary to maintain a conscious "problem-attitude"—an attempt to ascertain the differences between individuals both quantitative and qualitative. Study of this kind discloses that national coöperation cannot be achieved unless habit is based on contentment, and contentment is impossible without relative social equality, a clearer understanding of economic facts, and a greater positive liking by the individual for the work he does. The enjoyment of work can be increased only by a widespread and conscious policy of the better fitting of tasks to men and women. "An almost unimaginable increase of personal happiness, social contentment, and economic efficiency would result if the achievement of a more complete adjustment of tasks to individual differences became the organized and effective purpose of modern civilization." Educational policy appears to have but two alternatives—either sacrifice the above object and treat all children as nearly alike as possible to strengthen the idea of social equality and inculcate the principle of democracy, or sacrifice the latter ideal and base educational treatment on differentiation for the sake of diminishing human waste and realizing industrial coherence. The reviewer here is led to ponder: Is there not a way out of the difficulty through the very change in our social heritage of democracy, in which a new significance may attach to the principle in the light of knowledge regarding the distribution curve of intelligence?

In Chapter V the question of the means of controlling national coöperation is considered.

An examination of vocational organization reveals that with its advantages of human solidarity must ever be mixed the disadvantages of friction and confusion due to loss of zest in work which large-scale production involves because robbed of variety. Yet so marked is the tendency in man to shrink from change that it is hardly offset by the annoyance of monotony. "A workman who can shift from one process to another is more likely to feel zest in his work." There is greater gain from transferability than loss from decreased skill following each change, the author asserts, and flexibility is particularly necessary for neurasthenics, by whom "more than half the work of the world is done," according to a quoted physician.

The profession of the law, the most powerful of the English vocational organizations, shows the dangers of uncontrolled vocationalism most clearly. Mr. Wallas laments that the study of psychology does not form an important part of the lawyer's training, for the legal profession remains very nearly stationary as to its body of opinion concerning human motive. Its naïve and primitive conception of voluntary and involuntary acts has continued unrevised in British law since the seventeenth century.

The organized medical profession does not show the same shrinking from the effort of rehabituation, although it, too, receives some sharp thrusts. Its defects are perhaps more administrative than intellectual. So, also, certain machinery in the military profession is still retained because of ancient tradition, though indefensible in the light of present-day knowledge of psychological facts.

The teacher has enormously gained from the recent growth of professional organization, but in its train has come likewise the hostility to change. "Every new scientific discovery, every new movement of human thought, every change in the relation between states or races or classes, brings with it the need of a new distribution of the time and effort of teaching and learning." But vocationalism in this field is not keenly sensitive to these influences, for "standardization" is its objective. Professor Wallas gives somewhat extended attention to the "pecular psychology" of the teaching life, as he calls it, and its tendency toward nervous deterioration.

The psychological facts that give political force to the idea of liberty may be seen in the results that follow from the obstruction of human impulses. Obstruction by human agents produces a different reaction from that produced by non-human causes.

For civilized man the principle of liberty can never be absolute because his social heritage interposes the obstruction to his impulses. Pericles' conception of liberty showed more scientific insight than did that of Mill, whose celebrated essay, Wallas points out, failed to take account of the interaction of the impulse to lead and the impulse to follow which marks the process of coöperation. Mill's statement that "each individual is the proper guardian of his own health, whether bodily, mental, or spiritual," is hardly tenable in organized society.

Other traditional principles of natural rights, honor, and independence have arisen from certain psychological facts—viz., the reactions of unfreedom, wrong, and dishonor caused by the obstruction by human action of the normal function of some instinct. We have come to rely on the judgment of our public officials in determining the limits of these principles, when as a matter of fact experience has shown their decisions to be often in error. The author, for instance, holds the view that judges should be required to consult trained psychological assessors, and that it would probably be better that all criminal sentences be indeterminate and the whole treatment of prisoners after conviction be controlled by medical and psychological experts.

A thorough understanding of the psychology underlying these conceptions of liberty, right, independence, nationality, etc., must become widespread before we can reach the rational calculation and calculated action that will make world peace. On the other hand, it is true that the effect of acquaintance with science seems to be an increased feeling of helplessness in the individual facing this problem. Darwinian determinism makes wars more likely, psychological determinism diminishes personal initiative and responsibility. But neither can predict what may be the course of our social heritage of the future. If a renascence of intellectual energy should come, the organization of emotion now held by the church may take a new direction away from mysticism toward the object of world coöperation as a new compelling desire.

MIRIAM C. GOULD.

Vassar College.

AUGUST STRINDBERG: A PSYCHOANALTIC STUDY WITH SPECIAL REFERENCE TO THE ŒDIPUS COMPLEX. By Axel Johan Uppvall. Boston: Richard G. Badger, 1921. 95 p.

This is a curious sort of book. The author is an instructor in the Department of Romance Language at the University of Pennsylvania, although the study was made as a graduate student for a degree of

Doctor of Philosophy at Clark University. As an academic exercise in partial fulfillment of the requirements for a degree, it is, no doubt, satisfactory; as an examination and diagnosis of Strindberg, one may, at least, wonder.

One's puzzlement begins in the Preface. "This dissertation represents an effort to approach Strindberg's exceedingly complex personality from a psychoanalytic point of view." The analysis is to be along Freudian lines; not because the author accepts wholly the Freudian teachings, for he says that he doesn't, and not because he does not believe that Jung and Adler and Hall and others have contributed elements that are missing in Freud, for he says that he does, but—he comes awfully close to saying it—because it is easier than the "anagogic interpretation of psychic phenomena by Jung, Silberer, Maeder, and others" and, therefore, appeals to the "inexperienced analyst."

A student may choose an "easy" method in working at a problem if the problem is to be just an "exercise"; but once the "exercise" is accomplished and the requirements for the degree satisfied, why does it not still remain just an exercise and repose with the rest of the academic exercises in the archives of the college library? By what means does it suddenly become more than an "exercise" and impose itself as a book, as a result of which the publishers may announce that Strindberg "ceases to be an insoluble problem"; "like so many other men of genius, he labored all his life under the crushing weight of his Œdipus complex. His chaotic life demonstrates beyond a shade of doubt that he suffered from organ inferiority." What in all modesty started out as an "exercise" with a method admittedly inadequate, but deliberately chosen because it was the "easier for an inexperienced analyst," and was, after all, sufficient to satisfy the academic requirements, is now become a formal, presumably authoritative study and diagnosis of Strindberg, and the public is asked to pay money for it on this basis. The author may object that he has made a "study" of Strindberg and not a "diagnosis"; but that would be sophistry.

To prepare this thesis, it was necessary for the author, as a student, to familiarize himself with the literature of psychoanalysis (quite a different thing, however, from familiarizing himself with psychoanalysis clinically), to study as fully as possible the life of Strindberg, to examine carefully as much of what Strindberg wrote as is available, and to cull out those passages that seem significant. An excellent task as an exercise. And the task, undoubtedly, has been carefully and conscientiously done. Had the work stopped here and the degree been granted, there might have been a good "source book"—not adequate, perhaps, for is it possible for one dependent alone upon his knowledge of the "literature" of psychoanalysis even to pick out significant passages, except, perhaps, the more obvious and, therefore, not unlikely the least valuable ones? But as a book of selected source material it might have had value.

Whether this would have been sufficient to satisfy the requirements of a doctor's thesis, I do not know. Evidently the author felt not, for he does not stop, but proceeds to piece together a "cut-up" puzzle: Freud says this (quote) and this is what I have found in *A Fool's Confession;* Adler, loc. cit., writes (quote) and in *The Son of A Servant* Strindberg wrote (quote). Now and then, the author changes the formula to "If . . . and . . . and if . . . then this." At critical points he calls attention again, in all frankness, to the fact that his inexperience and lack of knowledge make him inadequate to judge certain material, but, with one condition piled upon another, he finally makes a judgment and then, straightway forgetting the way by which he has come— accepts the judgment as authentic.

The author's conclusions are that Strindberg (if . . . if . . . and providing . . .) was homosexual; that he suffered from a pathological psycho-sexual fixation on the mother; and that a "not inconsiderable hereditary *Belastung*" manifested itself in "organ inferiority and consequent hypertrophy of nervous function."

FRANKWOOD E. WILLIAMS.

The National Committee for Mental Hygiene.

THE PSYCHOLOGY OF SOCIAL RECONSTRUCTION. By G. W. T. Patrick. Boston: Houghton Mifflin Company, 1920. 260 p.

This book is a criticism of current programs for extensive social reconstruction on the ground of their failure to take full account of psychological factors; it is an interpretation of such plans "in the light of recent psychological studies—particularly studies in certain forms of instinctive behavior." The author expresses sympathy with the aims of social reconstructionists to better the condition of living for the masses, but insists upon proper psychological foundations.

The proposed reforms are political and economic, the author argues, whereas "life is determined by a great mass of inherited instincts, interests, and passions." The goal of social reconstruction should be the adaptation of the social order to the people who are to live in it. Men change slowly, while society develops rapid changes in organization, and the result is maladjustment. The proposed social reforms exaggerate the situation by abrupt efforts to adapt a new social order to man as he has existed for centuries. The citizens for the new society are lacking, declares the author, because "human beings will not serve." The proposed future is declared, for present-day human beings, to be "drab and uninteresting" and devoid of romance because it is built upon a pleasure economy, whereas man has struggled up through a pain economy. Long periods of education are needed to revise the instincts of man to fit the new order.

The discussion of the psychology of work adds to the limited literature of the vast subject of instincts in industry. The brief argument in this book shatters the idea that man loves to work and that he will be happy with short hours and good pay. The practices of efficiency experts to get the interest of workers by organization fare no better, because work in which the creative instinct of man has no part becomes drudgery. The future of industry depends upon giving an opportunity for the "instinct of workmanship." Industrial partnership is therefore favored. The author gives a hopeful view by pointing out that a large part of our workers—on the farms, in the small shops and individual employments—will have an opportunity for the development of the creative instinct and the "instinct of workmanship."

Interesting chapters, related to the main theme, are given on our centripetal society, social discipline, and next steps in applied science.

The book should have a wide influence because of its simplicity, directness, and incisiveness of statement. In reading it, one is reminded of one of the sayings of Mr. Dooley—in substance that a man who would promise to teach lobsters to fly in a month would be called a lunatic and be locked up, but the man who expects that people will be made good by an election is called a reformer and remains at large.

The book errs in painting the deficiencies of social-reconstruction plans too luridly. By no means do all plans so completely ignore the psychological factor. Practical social reformers have studied social behavior much more than is implied in this book. Even the politician is noted for crude, but effectual, understanding of people. However, the need is great, and an overstatement may draw attention where a more precise analysis would fail.

JOHN A. LAPP.

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THE BASIS OF PSYCHIATRY (PSYCHOBIOLOGICAL MEDICINE). By Albert C. Buckley, M.D. Philadelphia: J. P. Lippincott Company, 1920. 447 p.

The book is described as a "guide to the study of mental disorders for students and practitioners." With this intention of guidance in mind, one wonders where the student would be led by the first paragraph in the preface: "As the domain of general medicine in recent years has become considerably broadened and many of the newer facts have been brought to light through the channels of biology, and as the field of 'traditional general physiology' has become more or less fully occupied by experimental biology, so the mode of approach to the problems of psychiatry is following similar trends. This change in the direction of approach to psychiatry has come about through the development of a closer relationship between the subjects of biology and psychology; in fact, the two branches of science overlap to the extent that in the study of many problems it is difficult to determine where one begins and the other ends, for the reason that it is but the same 'science' viewed from different aspects."

One might question the accuracy of the statement that biology and psychology are the same "science" viewed from different aspects. Next comes a paragraph to the effect that the viewpoint that "psychology is a science of behavior" is being "widely accepted," but it is not clear whether the author accepts this viewpoint, nor does he discuss here the relation of such a viewpoint to psychiatry. Instead there follows: "As physicians and practitioners, we have come to consider the group of mental disorders which belong to the class of recoverable psychoses not primarily as mental diseases, but as reflections of some bodily disorder which, through its effect upon the organs of adjustment—the nervous mechanism and its lower and higher (psychic) reflexes—prevents the patient from making appropriate adaptations to environmental conditions, and therefore constitutes a thoroughly biological problem." The student might ask whether unrecoverable psychoses were not to be considered a reflection of "some bodily disorder," and one wonders whether the author considers that abnormal thinking and feeling and acting are necessarily such reflections. From the statement, however, that the "bodily disorder . . . constitutes a thoroughly biological problem," and from the statement in the Introduction that "mental phenomena, both in health and disease, are representatives of the biological reactions of the individual as a whole," one assumes that the author looks upon biology as the basis of psychiatry, and that all abnormal reactions in which psychiatry is interested had best be looked upon as biological phenomena. But that this is not an entirely correct assumption, apparently, is indicated by the reservation shown in the last paragraph of the Introduction: "Viewing the nervous mechanism as the organ of adjustment, and as a means by which not only organs and systems are governed, but also the organism as a whole is brought into adjustment with environment, the problems of psychiatry must be approached, *in part at least,* from the biologic viewpoint." (Italics the reviewer's.) The student may well ask himself whether he has misunderstood the author's previous statement, or whether, perhaps, the author himself was not quite clear as to whether or not psychiatric problems are *entirely* biological problems; he might ask, too, through what other avenues of scientific investigation the problems of psychiatry may be approached. He should be spared the pains. however, of searching through the book for answers to his questions, for he would not find, as the reviewer has not, an answer to his inquiry. Although *Psychobiological Medicine* is used as a subtitle for the book, the term is not used or explained in the text, and the student not familiar with Meyer's formulation of what he means by "psychobiology" would probably be doubtful as to its significance.

The main text of the book consists of two parts. Part 1 contains chapters on biological phenomena, cerebral development and receptive apparatus, mental development, psychological processes, etiological factors in mental disorders, exciting causes, classification, symptomatology, and methods of examination. Part 2 treats of the psychoses in particular, and includes chapters on psychoses with somatic diseases, toxic psychoses, general paralysis, the schizophrenic psychoses, the cyclothymic psychoses, the dementia-praecox, manic-depressive problem, psychoneuroses, psychopathic states, paranoia and paranoid states, psychoses with organic brain disease, and psychoses of the senile period. The author purposely omits consideration of the "agenetic types or defective groups," although the "purpose" is not indicated.

The chapter ón biologic phenomena in the first part covers 40 pages and includes descriptions of the nervous systems of the lower animals, a brief attempt at description of the form and development of the vertebrate nervous systems, brief reference to the functional divisions of the nervous apparatus, and a rather extended description of conditioned reflexes. In the same chapter is a section on heredity which contains detailed, lengthy presentations of the development of the sex cells, fertilization, Galton's law of inheritance, and the Mendelian law, with special reference to the fruit fly. The chapter ends with remarks on the crossing of plants. One feels the lack in this chapter of an application to the problems of man, and one is curious to know what determined the selection and segregation of the above mentioned topics as biological phenomena, especially when, in the next chapter, the development of the human brain and receptive organs is again taken up, with notes on the localization of function. The treatment of the latter is somewhat contradictory. The receptive organs are described as found in the lower animals; under "olfactory sense receptors" the illuminating statement is made: "Recently experiments have been conducted which seem to show that snails are provided with olfactory sense apparatus, though morphologically it has not been demonstrated." The vegetative nervous system is touched upon in a way that is not always clear as to the differentiation of the terms "vegetative," "autonomic," and "sympathetic," and it is maintained that "the importance of the autonomic system seems to have its greatest bearing in connection with mental states shown in the form of psychomotor reactions which accompany the various emotional states." In this statement, as is frequently the case throughout the book, just what the author means is not clear; we presume he does not believe that the main purpose of the vegetative nervous system is to function in the "various emotional states."

In the chapters on mental development and on psychological processes are found combinations of observations drawn from plant and animal reactions and the speculations of introspective psychologists. The latter chapter opens with the statement: "At the same time that the individual becomes aware of the effects of stimuli—that is to say, when a state of consciousness exists—he experiences additional subjective phenomena which are included within the meaning of the term 'mental.' These subjective experiences are collectively known as 'mental processes' and are to be distinguished from purely physical nervous (neuronic) phenomena." How much such discussions contribute to the understanding of human normal and abnormal behavior the author does not indicate. He apparently has not reached the point of considering the attempt to contrast mental and physical medically useless. In contrast to this lengthy description of other biological phenomena, the problems of the unconscious, with brief notes on the work of Freud and Jung, are treated in 4 pages. Nothing is said of the driving forces of the instincts, of wish-fulfillment, and of their influence on human behavior. The only reactions mentioned as resulting from lack of adjustment to conflicts are "hysterical and psychoneurotic." There is only a very brief reference to dream life, leaving the impression that the dream as a biological phenomena is of importance only as it indicates "mental trauma."

Under etiological factors, emphasis is placed on predisposition, which is held to be essential to the development of abnormal reactions, whatever other cause may be operative, and the author reasons in a circle that if a person develops a psychosis he is predisposed, and because of his predisposition he develops a psychosis. This predisposition, although its exact nature is unknown, is to the author dependent on some physical condition.

Under the heading, *Age as a Predisposing Factor,* is found a statement that middle life furnishes the greatest number and variety of psychoses, as "at this time mental development has been completed and typical reactions are thus made possible."

Under exciting causes are discussed infection and exhaustion (with notes on focal infections under the latter heading), toxic causes, and auto-intoxications. Internal secretions and disorders of glandular activity are considered under separate headings. Then comes a section on "disease toxins—syphilis and tuberculosis." Why they are separated from consideration with other infectious diseases is not indicated, but we do learn that gumma, meningitis, and endarteritis are excluded from "the syphilitic psychoses" because they are "organic brain diseases."

Under the heading, *Chronic Disease Not Primarily of the Nervous System,* along with anæmia, gout, and diabetes, "traumatic causes" are considered, with specific reference to the study by Meyer of head injuries. One wonders what these traumatic affections may be if they are not "primarily of the nervous system." We are also told here that "the mental symptoms accompanying sunstroke are produced as the result of meningitis," which is news to the reviewer and would be, he thinks, to most other medical men. Epilepsy, hysteria, Sydenham's and Huntington's chorea, traumatic neuroses, and paralysis agitans are discussed under the heading *General Nervous Diseases,* although it is clearly stated that hysteria is of psychic origin. Finally, as exciting factors, "psychic causes" are treated in a page, the author's attitude throughout the entire book being well represented by the statement: "The more carefully one investigates the factors supposed to operate in the production of mental disorders, exclusive of the psychoneuroses, through a direct action upon the mind, the less important do they appear to be." Emotions are alleged to affect the "general health"—"the physical health is undermined and the psychosis appears."

Personality and its influence on the psychoses are mentioned as having been considered "in recent years." Hoch's demonstration of "shut-in tendencies" is merely referred to, with no attempt at an explanation of the term.

In the chapter on symptomatology the old physical-mental difficulty comes out, as shown in the following paragraphs: "The symptoms of mental disorders are those which follow a disturbance, either functional or organic, in some part of the nervous pathway extending from the periphery to those centers and pathways concerned in the mental processes.

"Normal psychology studies, in the course of its investigation, sensation, perception, emotion, volition, and other mental processes. A study of psychiatry involves the consideration of the same mental processes which have become exaggerated or diminished in their capacity for action."

Thus a student would presumably be led to believe that "perception, emotion, volition, and other mental processes" affected are localized in "centers and pathways" in the nervous system, and so have his interests misdirected to seeking these out instead of concentrating on acquiring available facts regarding a patient's whole behavior—including the way he thinks and what he thinks about—and what determined such behavior. That it is the abnormal behavior of the individual that is essential is obvious from the symptomatology as given by the author under the headings ***Disorders of Perception, Attention, Consciousness, Orientation, Emotions, Memory, Train of Thought and Content of Thought.*** At the end of the chapter one meets without warning a short description, with diagrams, of Wernicke's "reflex arc" and "concept center," with no critical discussion, and one is left puzzled as to the why and wherefore of its introduction.

The chapter on methods of examination contains very satisfactory directions for the anamnesis. In line with the author's emphasis on "predisposition," a great deal of space is given to "stigmata of degeneracy" in directions for the physical examination. The mental-examination directions are essentially a repetition of the previous description of the symptoms. And one is reminded of a textbook on clinical pathology in the long and detailed description of the Wassermann-reaction technique, the spinal-fluid examination (in which errors are evident), and directions for the determination of blood alkalinity and urinary acidity; of the causes for the latter examinations no mention is made in the text. The advisability of an ordinary urinary examination and blood count is not suggested.

In the second part of the book, the various abnormal reactions are taken up in detail, following in general the classification of the American Psychiatric Association, and the reactions are in general treated as disease entities, with symptomatic descriptions under the headings already indicated in the chapter on symptomatology. For the so-called functional psychoses, the vague "predisposition" is insisted upon as the cause, with emphasis on physical factors and minimization of possible psychogenic factors. The relation of psychotic symptoms to conscious or unconscious strivings or wishes of individual patients is not discussed; the presentation contains only a very occasional attempt at a clinical picture of an individual case, and in no instance is an attempt made to bring all the facts together in the life story of a patient.

In the chapter on the manic-depressive, dementia-praecox problem, these psychoses are referred to as "biogenetic psychoses. These include psychoses the causes of which are unknown and concerning which the investigator is led into various speculative fields in the hope of being rewarded with the privilege of placing them in the category of definite toxic or organic psychoses." Just why such a placing should be a "privilege" is not indicated. Presumably it would not be an advantage to the patient? The fruits of the discussion, the value of which is left for the reader of this review to determine, are shown in the last paragraph of the chapter: "The dementia-praecox, manic-depressive problem appears to resolve itself into that which develops upon an inherently defective foundation. One is a fundamentally *qualititative* disturbance, the other *quantitative*. The dementia-praecox cases present an original defect, which is intensified by some as yet unknown operative cause. The manic-depressives represent an altered quantity in reaction without change in time. Success in establishing the difference in diagnosis between these two psychoses will depend upon the possibility of separating the two types of reaction."

It will no doubt be conceded that Dr. Buckley's book has demanded a great deal of time and effort in preparation, and that his attempt to present the subject of psychiatry as one of special biological reactions is to be highly commended; to write a comprehensive and satisfactory guide or textbook on psychiatry is no mean task. Whether the author's attempt has resulted brilliantly will be a matter of opinion, and the reviewer has attempted to present facts from the book to enable the reader to form such an opinion. The reviewer feels that there is left much to be desired with respect to consistency and breadth of viewpoint, choice of material, and conciseness and clearness of statement. One has a feeling that much of the subject matter, especially in the first part, does not hang together, and that to the student confusion would result. Divergent viewpoints are presented without critical discussion or digestion, a method always leading to difficulty for the reader who has not had sufficient experience to draw his own conclusions. It is felt, however, that these indicated alterations might well be made in subsequent editions so that the book might become one that could be recommended as a guide to the student and practitioner.

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MENTAL FATIGUE. By Gilbert E. Phillips, M.D., D.Sc. Thesis approved for the degree of Doctor of Science in the University of London, 1920. Sydney: William Applegate Gullick, 1920. 103 p.

In this publication, based on work done in the Psychology Laboratory of the University of London, the experimenter deals exclusively with mental fatigue, using Thorndike's definition of fatigue—"that diminution of efficiency which rest can cure."

Dr. Phillips discusses the production and transference of fatigue and the curve of fatigue and of recovery upon the basis of fairly well controlled tests, chiefly with multiplication and cancellation. The work is well described and illustrated by many tables and graphs. He presents many interesting conclusions, which, if further substantiated, ought to be of value to educators and employers seeking to stop short of excessive fatigue in their demands upon their workers. Some of his conclusions have already been quite generally accepted on the basis of other research—for example, that the beneficial effect of a rest is not proportional to its length if productivity is the criterion. He believes that for each task a rest may be estimated that will be long enough to dissipate enough fatigue and short enough to preserve some of the incitement effect. This has been worked out satisfactorily in some educational and industrial institutions.

His most interesting experiments are in regard to the transference of fatigue. He believes that fatigue is a general phenomenon, not specific to the task being performed, but that it effects specific powers differentially. "A subject whose power of multiplying deteriorates owing to general fatigue of all his powers may not deteriorate to the same extent, say, in memorizing or dotting." He likens this specific deterioration from a general cause to the successive loss of function in various areas of the brain under general anæsthesia. On the basis of tests involving very different ability, he comes to the conclusion that he is dealing with a specific transference of general fatigue rather than a transference of a specific fatigue to other tasks having large common factors, as some others believe. He finds a high average correlation between depreciations in the same test after various kinds of continuous work. The transfer of fatigue, then, is specific for each individual, and for each task that individual may perform. The question is not taken up whether there is a constant specificity for each individual. In applying this theory to education, he calls attention to the fact that the difficulties are greater than in applying the theory of specific fatigue for tasks with large common factors. His solution of the practical difficulty thus evolved is striking an average, or allowing the majority to rule in regard to the sequence in the daily curriculum. If Dr. Phillips' theory proves sound, the problem of change of task is far more complicated than merely avoiding long-continued work along similar lines.

In regard to the relative advantages of a change of work or a period of rest, he says, "We answer emphatically that change of task is not as good as a rest, but it may be better than no change of task at all or than an inadequate rest." Fatiguability, he concludes, is different for each subject, and susceptibility for fatigue is specific, not general. In other words, every task performed does not show a correspondingly large fatigue effect. Fatigue, he believes, does not depend upon the difficulty of the task, but upon the intensity of effort. When working at maximum effort, the rate of dissimilation is constant and involves the same amount of energy, whatever the task. Mental fatigue is apparently not due to a deposit of lactic acid in the brain, but is due to "a failure to produce by assimilation a sufficient amount of mental energy to balance its dissipation by dissimilation." This he believes is not constant for the individual, but varies with the task.

Dr. Phillips' work is intensive rather than extensive. It is subject to the same criticism that must be made of most laboratory investigations of fatigue—that the diagnosis of fatigue is made on rather inadequate data. Diminished capacity for work may be due to fatigue or it may be due to some other chemico-physical and psychic change lessening mental or physical output. Phillips refers t possible boredom, and has endeavored to counteract it. But can any laboratory experimenter ever be sure that no other possible emotional or physical causes were responsible for the diminished efficiency supposedly due to fatigue? It seems doubtful whether the innumerable inestimable subjective factors can be entirely eliminated, and the tests ever be purely objective. The diagnosis of fatigue in the individual is one of the most difficult we are called on to make, even after the most searching physical and mental examination. Yet, unless it is made in the individual, how can it be made in the aggregate? We need both intensive work along the line of Dr. Phillips and extensive work with a vast number of individuals under the most carefully controlled conditions before we can come to accurate conclusions either as to the nature of fatigue or the methods of testing it. And then we shall have the problem of applying our knowledge to everyday life.

The early part of this publication is taken up with a good review of the work of others in testing fatigue, by the methods now not generally accepted of the æsthesiometer, the ergograph, and tests with speed of reaction. There are many references to the literature on the subject of fatigue.

Florence L. Meredith.

Woman's Medical College of Pennsylvania.

THE CAUSES AND CURES OF CRIME. By Thomas Speed Mosby. St. Louis: The C. V. Mosby Company, 1913. 354 p.

It may be a platitude of the dullest order to say that we have forgotten the Great War and its lessons. We have forgotten it, probably, because we wish to forget it. Nevertheless, even the reviewer of books cannot escape constant reminders of it in the persistent cleavage that he finds between books written before the war and afterwards. This is true even in such remote subjects as criminology and matters connected with delinquency. It is true, therefore, of Mr. Mosby's book. Our general concepts have been so altered by the war and its results that even without looking at the date of this publication (1913) and after reading only a few pages, one is brought up abruptly by the persistent thought that had it been written in 1920, it would have been compiled from an entirely different point of view. The experiences of the last five years have shifted the interests, even of the most abstruse scientists, from the abstract to the concrete—from particular artificial groups, in which the individual disappears, to the individual himself.

Mr. Mosby's book deals with the vague entity that is called "crime." It tells us almost nothing about what we are most interested in—namely, about the criminal himself; about that varying type of personality which refuses to merge itself in the routine of action imposed from the outside by law, and which meets with certain unpleasant resistances in its effort to make its own kind of adjustment to objective demands. Curiously enough, Mr. Mosby seems to have felt this need of making a book on crime valuable by an attempt to understand the human elements that create it, and without which it is, itself, but an empty word. For he has scattered throughout his book a series of interesting photographs taken from the records of the police department of Kansas City; photographs of individual law-breakers arranged in groups— types of burglars, of forgers, of murderers, and of other delinquents. These photographs, however, have not the slightest connection with the text of the book. They are not even mentioned in it. Had Mr. Mosby been able to write, let us say, a chapter on forgery, based on a study of the personalities of those individual forgers whose photographs are included in his work, and had he been willing to base his theories and conclusions concerning the crime of forgery on the analysis of such antisocial individuals, he would have made a definite and more or less valuable contribution to criminology. He has chosen, however, to treat what he calls "crime" in the manner of a man lecturing before a Chautauqua audience on Mesopotamia, who gives his hearers a general discussion on *Wanderlust*, on the psychology of traveling, on the types of steamships and railways plying between America and the Far East—adding, perhaps, a carefully arranged curve based on the percentages of travelers who, on their way to Mesopotamia, are attacked by seasickness as compared with those who are so attacked in traveling to European ports, together with another concise table of the fees extorted by the steamship stewards—but tells his audience nothing definite about the people who go to make up that particular part of the world called Mesopotamia, their habits, customs, and the elements that distinguish them from the inhabitants of Main Street, Peoria, Illinois. All this may seem ungracious criticism of a writer who has evidently at heart the welfare of his fellows, and who is attempting to interest the general public in one particular class of his less fortunate fellow-beings.

Perhaps the most interesting element in Mr. Mosby's book is his treatment of his subject from a quasi-medical point of view. He divides his book into three divisions: etiology, or the causation of crime, cosmic, social, and individual; prophylaxis, or the prevention of crime, under which head he treats of eugenics, asexualization, and social amelioration; and therapeutics, or cures for crime, under which he discusses punishment and the theory of punishment, the indeterminate sentence, parole, and what he calls the new penology. It would be unkind and unnecessary to pick flaws in these various chapters, for after all the main fault in the entire work is the basic one that has already been mentioned—namely, the treatment of the problem from the standpoint of the social group instead of from that of the individual. The group of people whom Mr. Mosby calls "criminals" is an unreal thing that cannot be distinctly and scientifically defined, and that runs over imperceptibly into the mass of general humanity. The individual law-breaker, on the other hand, is something definite, something that can be studied and perhaps—understood. He, too, of course, cannot be absolutely bounded by lines of criminal demarcation. He also runs over in the boundaries of his personality into law-abiding activities. He is not always the law-breaker and always antisocial. If he were, the problems of his personality would be much simpler. Nevertheless, he is more concrete and more susceptible to analysis than that loosely defined artificial group of delinquent individuals which is called "the criminal class." To use another illustration, Mr. Mosby is like a scientist engaged in writing a book on chemistry, who discourses in general terms on some complex chemical compound which contains innumerable radicals many of which are yet unknown to science, instead of attempting to study the nature of the molecules or the atoms which are the basic elements composing all chemical substances. Without a knowledge of the nature and activities of the atoms, the writer would surely be unable to give to his readers any abidingly useful conclusions about his complex substance.

However, accepting Mr. Mosby's viewpoint as it is, one feels bound to congratulate him on the great amount of reading that he has done in preparation for his book, for the spirit of kindliness and understanding in which it is written, and for the loving care that he has lavished on the entire work. It is true that his reference to other writers are often somewhat vague, and that in many instances he does not cite chapter and verse of his authority, so that one can verify his references. One gets also an impression that several chapters of the book were delivered as addresses at various times. The style frequently changes abruptly from the quiet reasoning of the scientist in his study to the impassioned, somewhat highly colored speech of a lawyer addressing a body of his colleagues, or endeavoring to convince an apathetic jury.

The chapter on parole contains a useful summary of the parole laws that were in force in the different states of the Union in 1913. Unfortunately, however, it is the fate of such compilations to become rapidly out of date, because of the constant changes in the state laws each year. Nevertheless, Mr. Mosby's compilation will be valuable as a foundation for similar statistics in the future.

Perhaps the most interesting chapter is that dealing with the theory of punishment and the vexed question of capital punishment. Mr. Mosby feels, as many other lawyers do, that capital punishment should cease. Any one who has ever been forced to be present at an American execution will without doubt agree that the present mode of the infliction of the death penalty is brutal and unnecessarily cruel. This is especially true of hanging, even when it is most carefully managed. But because our present methods of inflicting capital punishment are so abhorrent, it does not follow that death, as the supreme penalty for certain crimes, is in itself wrong and barbarous. The objection to capital punishment in the minds of most men has its roots in an overemphasis on the value of human life. Those of us who have spent any length of time in the Far East, where the individual human life is of little value and where capital punishment is inflicted for numerous offenses, but inflicted almost instantly and with a minimum of suffering, cannot always share the average man's aversion to the death penalty. Moreover, many others who were brought into close contact with the events of the Great War learned the relative unimportance of the individual life. Men with this reference became accustomed to see or to hear of the deaths of thousands—not of mentally deficient or of antisocial law-breakers, but of the very best of our own manhood. They have, as a result, never been able to readjust their ideas to former standards and have little patience with the wastage of time and money spent in deciding between the life or the death of some low-type murderer, whose existence is of no value to any one and without whom the world would be decidedly cleaner and better. This is only another one of the many points in which Mr. Mosby's own mental reactions would probably have been clothed in somewhat different language had he written his chapter on capital punishment to-day instead of eight years ago.

On the whole, those of us who are interested in the problems of delinquency must be grateful to Mr. Mosby for his book, and for all the labor that he has undertaken in producing it. Even if one does not entirely agree with his point of view, the book stimulates discussion and is written with enough freedom and brightness of style to interest the man in the street. And after all, the man in the street is the person whom it is important to reach.

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Medical Service, Supreme Bench of Baltimore.

SYPHILIS OF THE CENTRAL NERVOUS SYSTEM; ITS PATHOGENESIS AND TREATMENT. By Wilhelm Gennerich. Berlin: Julius Springer, 1921. 270 p.

In this monograph Gennerich discusses the causes and treatment of syphilis of the central nervous system. The study is based upon the results of treatment of cases of syphilis with involvement of the nervous system, in an endeavor to learn what can be accomplished. Gennerich divides the cases roughly into those that have been treated with mercury before the salvarsan days, those that have been treated with salvarsan and mercury combined, and finally those that have been treated by the intraspinal method. His work is probably the most extensive study that has been made of this subject. He takes up the various types of central-nervous-system syphilis, including the early cases that present no definite symptoms, but in which there is evidence of an invasion of the central nervous system by the spirochete, and the various types of clinical cerebro-spinal syphilis, tabes, paresis, and the like. There is, in addition, a good deal of theoretical discussion. Much of his theory is subject to severe criticism and his methods of treatment are not as inclusive as one might wish; nevertheless, it would seem that this work is the most satisfactory that has yet been produced on the subject of the effect of treatment upon syphilis of the central nervous system.

Gennerich is a syphilologist of note whose interest in syphilis of the central nervous system is incidental to his interest in syphilis as a general disease. He has, therefore, certain advantages over the neurologist and the psychiatrist who study the manifestations of nervous-system syphilis in that he has a background and case experience which have given him a view of the whole life picture of the disease. It seems to us that this book offers a basis for more fundamental study of nervous-system syphilis than has as yet been made. It would seem to be of the utmost benefit to every neuropsychiatrist who deals at all with the prevention, care, and treatment of cases of neurosyphilis.

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TRAITÉ DE PATHOLOGIE MÉDICALE ET ED THÉRAPEUTIQUE APPLIQUÉE: NEUROLOGIE. Edited by Emile Sergent, L. Ribadeau-Dumas, and L. Babonneix. Paris: A. Maloine et Fils, 1921. 2 vols.

These two volumes on neurology are part of a large system of medicine. The neurological volumes really make up a system of neurology by a number of different neurologists. The list of the contributors to the neurological section appears like a list of "Who's Who in French Neurology": Pierre Marie, Foix, Régnard, André Thomas, Sézary, Mme. Dejerine, Gauckler, Stéphen Chauvet, Guillian, Babonneix, Roger Voisin, Laignel-Lavastine, Froment, Sicard, Tinel, Lhermitte, Crouzon, G. A. Weill, Souques, Chatelin, R. Voisin, Cl. Vincent, Roussy, DeMartel.

One misses the name of Babinski, of course.

The volumes represent an excellent textbook or reference book on the entire subject of neurology, including the new war material. We find of especial interest the question of aphasia, with a discussion of a super-marginal region as an important aphasic center, and a discussion of the recent contributions of Marie, Foix, and Bertrand.

The discussion of hysteria contributed by Clovis Vincent gives a very excellent summary of the French concept of hysteria as developed by Babinski.

Altogether, the books represent a very modern picture of neurology. It is all written in the delightfully simple and systematic fashion of the French. Everything is made very understandable. The work does not represent the profundity of Oppenheim's textbook. It is by no means as rich in references, and therefore will not prove as great a source of information to the expert neurologist as it might otherwise be, but it should still be of great value indeed to the student and the general practitioner, and to the neurologist who wishes to refresh his mind quickly or to get a late point of view on any neurological subject in a brief line.

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NOTES AND COMMENTS

Delaware

"In order that the State of Delaware may serve the welfare of its children adequately," a Child Welfare Commission has been created by legislative enactment. The commission is to consist of nine members appointed by the governor. The duties of the commission are thus defined: "To take over and further to develop the child-welfare activities conducted by the Reconstruction Commission of the State of Delaware; to maintain a traveling child-health center to serve the sparsely settled sections of the state; to coöperate with state, county, and local bodies in the development of such child-welfare work as the commission may believe will materially advance the interests of the children of the state; to make every reasonable preparation to transfer various branches of its work as rapidly as possible to appropriate state agencies; to make a study of the needs of children a definite part of its work; and to make recommendations for executive and legislative action in matters relating to children."

Over $300,000 has been granted to the Delaware State Hospital to be expended for permanent improvements.

Idaho

A reception hospital is being constructed at the Idaho state hospital at Blackfoot.

Kansas

Chapter 282, Laws of 1921, authorizes the establishment at the University of Kansas of a Bureau of Child Research. Its activities are to be as follows: "Studying the problems of the child life of the state, including studies as to the diagnosis, treatment, and prevention of delinquency, defectiveness, and dependency; studies in normal inheritance, development, and training; studies of family and community life in their relation to child life."

Michigan

Counties are empowered to provide for the care of their feebleminded and epileptic persons, by the terms of a law passed by the 1921 legislative assembly. The several courts of the state having jurisdiction over proceedings relative to feebleminded and epileptic persons may commit such persons to these county institutions. Reimbursement for their maintenance is made by the state to an amount equal to the cost of maintaining patients in the state institutions.

A State Welfare Department has been created, consisting of a director as its executive head and the following commissions: the State Welfare Commission, the State Hospital Commission, the State Prison Commission, the State Corrections Commission, and the State Institute Commission. The director and members of each commission are to be appointed by the governor with the advice and consent of the senate. The State Welfare Commission is to be the legal successor to the Board of Corrections and Charities. The State Hospital Commission is to be the legal successor to the several boards of trustees and boards of control of the state hospitals for mental diseases and the state institution for epileptics. The State Prison Commission has jurisdiction over the state prison, the reformatory, and the house of correction. Under the jurisdiction of the State Corrections Commission are placed the following institutions: the State Industrial Home for Girls, the Industrial School for Boys, and the Michigan State Training School for Women. The State Institute Commission has control of the state institutions for the deaf, blind, and feebleminded and the state public school. The board of trustees of the State Psychopathic Hospital, after the passage of this act, is to consist of four regents of the University of Michigan, and of four other trustees selected by the governor. The State Psychopathic Hospital is deemed to be within the State Welfare Department for purposes of visitation and inspection, but not for the purpose of controlling the action of its board of trustees, nor for the purpose of exercising any jurisdiction over the management and policy of the hospital.

The Director of the State Welfare Department and the State Hospital Commission, or any member or agent appointed by either, shall have supervisory and visitorial powers over every private hospital, institution, or home in which persons mentally diseased are cared for.

Nebraska

Chapter 240, Laws of 1921, states that minors who in the judgment of the juvenile court are delinquent, dependent, defective, or neglected and require institutional care shall be wards of the state and committed to the custody of the board of control. This law also provides for the appointment of a clinical psychologist who is to conduct investigations and study the problems relating to dependent, defective, and delinquent children.

The names of the state hospitals for mental diseases have been changed by legislative enactment to Lincoln State Hospital, Norfolk State Hospital, and Hastings State Hospital. These hospitals formerly had the phrase "for the insane" in their titles. The name of the state school for mental defectives has been changed from Nebraska

Institution for Feebleminded Youth to Nebraska Institution for the Feebleminded.

By the terms of Chapter 245, Laws of 1921, it is unlawful to admit or maintain any child under sixteen years of age or any pregnant woman in any poorhouse in the state.

Nevada

Chapter 149, Laws of 1921, authorizes the Board of Commissioners of the Nevada Hospital for Mental Diseases to provide suitable quarters for the treatment of ex-service men of the World War who may be suffering from "shell shock" or other mental diseases, and who in the judgment of the superintendent should not be confined with other patients of the hospital.

New Jersey

Chapter 134, Laws of 1921, provides for the retirement with compensation of any person who has been continuously in the employ of the state for a period of twenty-five years. The employee must have reached the age of sixty years and be physically or otherwise incapacitated for service, and the disability must have developed during his term of service. The applicant for retirement must be examined by a physician who must make a report of the disability and state his opinion whether it will continue permanently and prevent the applicant from the performance of his duties. Compensation is to be at the rate of one-half of the average annual salary the employee has been receiving the two years previous to the filing of his resignation.

New Mexico

A State Department of Public Welfare has been created by legislative enactment. It is to consist of a Board of Public Welfare with a Bureau of Public Health, a Bureau of Child Welfare, and whatever other divisions may be necessary. The Board of Public Welfare is to appoint a Director of Child Welfare, who must be a woman of experience and special training in child-welfare work, and a Director of Public Health, who must be a person having experience and special training in sanitary science and public-health work.

North Carolina

A law authorizing the commitment of inebriates was enacted by the 1921 legislature. If any person adjudged to be an incompetent is an inebriate, the clerk hearing the case shall commit him to the department for inebriates at the State Hospital at Raleigh. The term inebriate is thus defined: "A person so addicted to alcoholic drinks or narcotic drugs as to be a proper subject for restraint, care, and treatment." Inebriates may also be sent to the department for inebriates of the hospital mentioned upon the petition of wife, husband, parent, or child, committee of estate, or a friend, with the affidavit of two reputable physicians.

A law has been enacted which would forbid the issuance of a marriage license except upon a certificate showing, if the applicant is a male, the nonexistence of any venereal disease and of tuberculosis in an infectious form, and that he is not an idiot, imbecile, or of unsound mind. If the applicant is a female, the certificate must show absence of tuberculosis and that she has not been adjudged of unsound mind. The certificate is to be signed by a reputable physician of the county.

A bond issue of over six million dollars has been authorized, one half to be issued in 1921 and the other half in 1922. The fund is to be devoted to the enlargement and permanent improvement of the educational and charitable institutions of the state. The hospitals for mental diseases will receive over one million dollars and the institution for the feebleminded $240,000.

North Dakota

A Children's Code Commission has been created by an act of the 1921 legislature. It consists of seven members appointed by the governor from members of the State Conference of Social Work, the State Federation of Women's Clubs, the State Medical Association, the State Bar Association, the State Educational Association, the State Federation of Labor, and the State Minimum Wage Department. This commission is to study social conditions touching upon the welfare of children and recommend necessary revision and codification of existing laws, and such new laws as are needed. It must make a detailed report with its findings and recommendations to the next legislative assembly and to each succeeding legislature during its period of existence.

South Dakota

Chapter 232, Laws of 1921, provides for the extradition of persons of unsound mind. This law is similar to laws in effect in Illinois, Maryland, Massachusetts, Nevada, Tennessee, Virginia, and Wisconsin.

Vermont

An appropriation of $15,000 has been made for a shelter home, where dependent, neglected, and delinquent children committed to the care of the Board of Charities and Probation may receive physical and mental examination before being placed in private families.

Chapter 221, Laws of 1921, makes it unlawful to keep any dependent child in a poorhouse, except a child under two years of age with its mother. In cases of emergency an exception is made, but not to exceed ninety days.

In accordance with Chapter 224, Laws of 1921, when a child comes into the custody of a juvenile court, the court, before making a final determination of the case, is empowered to order a physical and mental examination to be made by a competent physician appointed by the court.

Washington

A law to prevent the procreation of persons who are feebleminded, insane, epileptic, habitually criminal, morally degenerate, or sexually perverted who may be inmates of state institutions has been enacted. This law provides for the sterilization of such persons upon the decision of a majority of the Institutional Board of Health of the state, if in their judgment procreation would produce children with an inherited tendency along these lines and if there is no probability that the condition of such persons will improve so as to render procreation advisable, or if the physical or mental condition of such persons will be substantially improved thereby. The superintendent of the institution is then authorized by the board to perform or cause to be performed such type of sterilization as may be deemed best by the board. The purpose of the law is thus stated: "For the betterment of the physical, mental, neural, or psychic condition of the inmate, or to protect society from the menace of procreation by said inmate, and not in any manner as a punitive measure; and no person shall be emasculated under the authority of this act except that such operation shall be found to be necessary to improve the physical, mental, neural, or psychic condition of the inmate." Provision is made for appeal from the decision of the board.

The state of Washington enacted in 1909 a sterilization law that applied only to persons adjudged guilty of carnal abuse of females under ten years of age or of rape, or adjudged to be habitual criminals.

Wyoming

The name of the Wyoming School for Defectives has been changed by law to the Wyoming State Training School.

Chapter 16, Laws of 1921, allows the granting of a divorce when either husband or wife has become incurably insane. However, no divorce shall be granted unless such insane person has been confined in an institution for the insane for at least five years preceding the commencement of the action for divorce, or unless it shall appear to the court that such insanity is incurable. Furthermore the plaintiff must be a resident of this state, and shall have resided there for one year next preceding the beginning of such action.

Hawaii

A law has been enacted to establish a psychological and psychopathic clinic to investigate the nature, causes, treatment, and consequences of mental disease and defect within the territory. The management of this clinic is to be vested in the Board of Regents of the University of Hawaii. The Board of Regents is empowered to employ a competent person or persons to have charge of the clinic, to conduct investigations, to publish results of such investigations, and to give lectures and other forms of instruction pertaining to mental disease and defect. The clinic will receive for observation or examination persons who come at the request of court judges, of the superintendent of the juvenile industrial schools, of the hospital for mental diseases, of the department of public instruction, or of any other public institution or organization within the territory. Subject to regulations, the clinic may make examinations or investigations at the request of any private, charitable, or benevolent institution or organization, or of any parent or guardian. An appropriation of $15,000 is made for the establishment of the clinic and for its maintenance until July 1, 1923.

UNIFORM STATISTICS FOR INSTITUTIONS FOR THE FEEBLEMINDED

The American Association for the Study of the Feebleminded, at its annual meeting in Chicago in 1919, adopted a resolution that the president of the association appoint a committee on uniform statistics and invite the coöperation of the Bureau of Statistics of the National Committee for Mental Hygiene. The committee thus appointed consisted of the following members: Walter E. Fernald, M.D., Chairman; H. A. Haynes, M.D., F. Kuhlman, Ph.D., George Mogridge, M.D., and J. Morehead Murdoch, M.D. This committee has met with the Bureau of Statistics of the National Committee for Mental Hygiene and given careful consideration to various plans. As an outcome of their deliberations a statistical system for institutions for the feebleminded has been developed and is now being introduced throughout the country. The system was approved by the association at its annual sessions in 1920 and 1921 and is meeting with general favor. It has been in force in two states for some time and many other institutions have signified their willingness to adopt it. A Statistical Manual containing the association's classification of mental defect and detailed suggestions for the preparation of annual statistics has been published and is being distributed without charge to superintendents of institutions for the feebleminded. In response to many requests that have been received from these institutions, there has been printed a series of schedule cards for records of first admissions, readmissions, discharges, deaths, and transfers. These cards are being supplied at cost to institutions, upon the order of the superintendents. Tabular forms are being prepared which will be distributed without charge to coöperating institutions for the compilation of annual statistics.

SECOND INTERNATIONAL CONGRESS OF EUGENICS

The Second International Congress of Eugenics was held in the American Museum of Natural History, New York City, September 22-28, 1921. The following governments were represented by delegates: Belgium, Brazil, Canada, Cuba, Chile, Costa Rica, Czechoslovakia, Denmark, Guatemala, Nicaragua, Norway, Peru, Salvador, Siam, Uruguay, and Venezuela. England, France, Tunis, Italy, and Mexico were represented by delegates from learned societies and universities.

Many different parts of the United States were represented in the American delegation, which was large. The following states sent official delegates appointed by the governor: Georgia, Iowa, Kansas, Minnesota, Mississippi, Maryland, Nevada, New Jersey, New York, Ohio, and Virginia. The United States Public Health Service also was officially represented.

The formal opening of the Congress was held for delegates and guests on Thursday evening, September 22. Dr. Henry Fairfield Osborne, of the American Museum, President of the Congress, presided and gave the address of welcome. Major Leonard Darwin, President of the Eugenic Education Society of Great Britain and Presiding Officer at the First Eugenics Conference, delivered the opening address on *The Aims and Methods of Eugenic Societies.* Dr. Charles P. Davenpart, of Cold Spring Harbor, founder of the eugenic movement in America, read a paper on *Research in Eugenics.*

For the remaining sessions the Congress met in four sections.

Section I, on Human and Comparative Heredity, held five sessions. The leading address was given by Dr. Lucien Cuénot, of Nancy, France, on *Adaptation and Modern Genetic Conceptions.* The papers presented dealt with investigations in the domain of pure genetics in animals and plants and with studies in human heredity. The rôle that heredity plays in mental traits of the human race was discussed in the following papers: *Pedigree of Pauper Stocks,* by Mr. E. L. Lidbetter, London, England; *Inheritance of Mental Disorders,* by Dr. A. J. Rosanoff, Clinical Director, Kings Park State Hospital, Kings Park, Long Island, New York; *Inheritance in Mental Disorders,* by Dr. Henry A. Cotton, Medical Director, New Jersey State Hospital, Trenton, N. J.

Section II, on Eugenics and the Human Family, held three sessions. Dr. Lucien March, of Paris, France, gave the leading address on *The Consequences of War and the Birth Rate in France.* Among the papers presented, the following deserve special mention: *Some Scientific Aspects of Genealogy,* by David Starr Jordan, Leland Stanford Junior University, Leland Stanford, California; *Measurement of Family Resemblances in Intellect,* by Dr. E. L. Thorndike, Columbia University; *The War from the Eugenic Point of View,* by Dr. Corrado Gini, Rome, Italy.

Section III, on Human Racial Differences, held two sessions. The opening address was given by Dr. G. V. deLapouge, of Poitiers, France, author of the *Fundamental Laws of Anthropo-sociology, The Social Rôle of the Aryan,* and other treatises, who discussed *Race among Mixed Populations.* Papers were presented dealing with intermarriage between races, race amalagamation, mortality rates among different races, and physical characteristics of races.

Section IV, on Eugenics and the State, held five sessions. Major Leonard Darwin's address on *The Field for Eugenic Reform* gave the keynote to this phase of eugenics. The general thesis of the paper was that the aim of the eugenist is to increase the rate of multiplication of good stocks and to decrease that rate among the less fit. In the United States there are at least 300,000 or 400,000 feebleminded persons, and it is certain that they will pass on this defect to many of their children, while their normal offspring may also be endowed with the power of transmitting it to posterity. Segregation of this class would be one solution of this problem, but the feebleminded individual often attracts affection and his removal from home is frequently resented. Permission to live at home should be granted when all conditions are suitable and when parenthood is impossible. If on further investigation sterilization proved to be harmless, and if it were voluntarily adopted, these things might be allowed to tell in favor of such permission being granted. Major Darwin favored the introduction of sterilization as a voluntary and experimental measure. Turning to the consideration of good qualities, he advocated raising the level of the whole people in regard to their inborn qualities rather than the selection of a number of highly endowed persons who should be induced to marry and encouraged to produce large families. Among the other papers presented, the following deserve special mention: ***Some Eugenic Aspect of the Problem of Population,*** by Dr. Raymond Pearl, Johns Hopkins University, Baltimore; ***Eugenics as a Factor in the Prevention of Mental Disease,*** by Dr. Horatio Pollock, New York State Hospital Commission, Albany; ***Eugenical Sterilization in the United States,*** by Dr. H. H. Laughlin, Eugenic Record Office, Cold Spring Harbor.

In connection with the Congress an exhibit was held from September 22 to October 22 at the American Museum of Natural History. Emphasis was given at this exhibit to the popular aspects of eugenics. Charts, maps, pictures, and models demonstrating eugenic principles were adequately organized for presentation to the general public. From the mental-hygiene viewpoints the exhibits from Waverley and Vineland were especially interesting and instructive.

It was gratifying to note the interest in the Congress shown by the general public. The leading papers gave daily considerable space to the proceedings. The sessions and exhibits were well attended, and the audience took a lively interest in the discussion of the papers. The teachers of special classes of New York City were instructed to attend the meetings of the Congress and various other institutions and social agencies likewise availed themselves of this unusual opportunity and were represented in large numbers.

HARTLEY FOUNDATION

Public-health, mental-hygiene, and probation work, not only in Connecticut, but also in other states, are the purposes announced by the Hartley Foundation, which was recently granted a special charter by the Connecticut legislature. The foundation held its first meeting, July 19, at Norfolk, and the founder, Mrs. Helen Hartley Jenkins, New York, was chosen president, and her attorney—Robins S. Stoeckel, Norfolk—secretary-treasurer. Dr. Samuel A. Brown, Dean of Bellevue Hospital Medical College, was made a member of the executive committee. The foundation was established in memory of Mrs. Jenkins' father, the late Marcellus Hartley, former head of the Remington Arms Union Metallic Cartridge Company, and the funds made available by Mrs. Jenkins are said to total several millions. The public-health department of the corporation will put its facilities at the disposal of the state or any subdivision of it in case of epidemics or other emergencies. It will carry on mental-hygiene work in connection with prisons, reformatories, and other institutions.

LECTURES ON MENTAL HYGIENE AT THE NEW SCHOOL OF SOCIAL RESEARCH

A course of lectures of unusual interest and importance on ***Mental Hygiene and Its Social Bearings*** has been announced by the New

School of Social Research, 465 West 23d Street, New York City. Sixteen well-known psychiatrists will combine in giving the course, each lecturer dealing with a phase of the subject to which he has given special attention. Throughout the course the social significance of the various mental-disease groups will be emphasized. Only so much of the medical aspect of the groups will be given as is necessary in the forming of a background for the discussion of the social factors involved.

The course will open October 10. The list of lecturers and their subjects are as follows:

Lecturer	*General Subject*
Dr. Thomas W. Salmon	Introduction.
Dr. John T. MacCurdy	Medical Psychology: Biological Position of Mental Function. Reaction Types. Experimental Mental Methods. The Unconscious. Dynamic Theories. Psychoanalysis. Psychology of the Emotions.
Dr. Clarence O. Cheney	Personality.
Dr. L. Pierce Clark	Hysteria. Anxiety States. Compulsions and Obsessions. Neurotic Adaptations. Traumatic Neuroses. Epilepsy.
Dr. Harry C. Solomon	General Paresis and Syphilis.
Dr. Adolf Meyer	Trauma.
Dr. William A. White	Arteriosclerosis and Senility. Apoplexy and Aphasia.
Dr. George H. Kirby	Alcoholic and Drug Psychoses and Addiction.
Dr. William A. White	Paranoia. Dementia Praecox. Psychology of Adolescence.
Dr. John T. MacCurdy	Involutional Reactions. Psychology of Senescence.

Dr. George H. Kirby	**Manic-depressive Insanity.**
Dr. Morton Prince	**Psychology of Spiritism.**
Dr. Bernard Glueck	**Psychopathic Personality.** **Delinquency.**
Dr. Walter E. Fernald	**Feeblemindedness.**
Dr. V. V. Anderson	**Special Problems in Feeblemindedness.**
Dr. John T. MacCurdy	**Psychology of War:** **Mobilization.** **Warfare.** **Demobilization.**
Dr. Pearce Bailey	**Social Value of the Neuropsychiatric Examinations in the Army.**
Dr. Frankwood E. Williams	**Mental Hygiene and Education.** **Mental Hygiene and Industry.** **Function of Psychiatric Agencies.**
Dr. Adolf Meyer	**Psychiatry and Eugenics.** **Psychiatry and Sex Hygiene.**
Dr. William Healy	**Psychiatric Problems of the Individual.**
Dr. Thomas W. Salmon	**Relation of Psychiatry to Future Development of Community Life.**

Other courses announced for this year by the New School for Social Research which will be of interest to mental hygienists are the *Biological Basis of Personality and Conduct* by Edward G. Conklin; *Studies in Social Behavior* by Everett Dean Martin; *The History of the Human Mind* and *The Modern Historical Antecedents of the Present Intellectual Outlook* by James Harvey Robinson; *Psychological Problems of Educational Reconstruction* by Joseph K. Hart.

SMITH COLLEGE TRAINING SCHOOL FOR SOCIAL WORK

The Smith College Training School for Social Work completed its third year on September first. Begun as a war emergency to provide psychiatric social workers for military hospitals, the school has been continued and its scope enlarged as the type of work offered has seemed to meet a growing need in the field of social work. During the past summer courses were given leading to certificates or diplomas in psychiatric Social Work, Medical Social Work, and Community Service. Those enrolled were graduate students from Smith College, Wellesley, Vassar, Bryn Mawr, Mount Holyoke, and various state universities; sixteen states were represented. The teaching staff was composed of F. Stuart Chapin, Director, of Smith College; Mary C. Jarrett, formerly Chief of Social Service, Boston Psychopathic Hospital, Associate Director; Everett Kimball; David Camp Rogers; Chase Going Woodhouse; James H. Sinclair, of Smith College; Dr. Florence L. Meredith, Professor of Hygiene, Woman's Medical College of Pennsylvania; Anna F. Davies, Head Resident, Philadelphia College Settlement; Dr. John A. Houston, Superintendent, Northampton State Hospital; Dr. Frankwood E. Williams, Associate Medical Director, The National Committee for Mental Hygiene. Among the visiting lecturers were Dr. Walter E. Fernald, Dr. C. Macfie Campbell, Dr. Walter E. Timme, Dr. L. Pierce Clark, Dr. A. A. Brill, Prof. William H. Burnham, Dr. Edith R. Spaulding, Dr. A. Warren Stearns, Dr. A. Myerson, Dr. Wade Wright, Dr. Woods Hutchinson, Dr. Harry C. Solomon, Mr. Porter R. Lee, Miss Mary Van Kleeck, Miss Ida M. Cannon, Mr. Michael M. Davis, Jr., and Prof. James H. Tufts.

LECTURES ON SOCIAL BEHAVIOR AT BOSTON UNIVERSITY

Professor Ernest R. Groves, of the Department of Social Sciences of Boston University, will give this year a series of lectures on *Social Behavior and Human Progress* as one of the Evening Extension Courses of Boston University. The course will consider man's social behavior in its relation to the problem of social improvement and will aim to give teacher, parent, student, and citizen a survey of the contemporary thinking and undertakings that throw light upon the task of advancing individual and social standards of life. Among the topics to be considered are: The background of social behavior and some control problems; Recent sociological thinking with reference to social progress, including Conklin, Patten, Korzybski, Todd, Ross, Dealey, and Sidis; Recent contributions to social progress, including mental hygiene, psychoanalysis, and the correction of social maladjustment, Adler's inferiority complex, and the task of social compensation and humanizing of industry.

NEED OF A NEW PSYCHOPATHIC HOSPITAL FOR CONNECTICUT

On August 16th Governor Lake appointed a special commission to investigate the need of a new state psychopathic hospital. The commission consists of Dr. M. C. Winternitz, Dean of Yale School of

Medicine, New Haven; Dr. Paul Waterman, Hartford; Dr. C. Floyd Haviland, Superintendent, Connecticut State Hospital, Middletown; George S. Palmer, New London; and John Cavanaugh, South Norwalk.

MENTAL HYGIENE DIVISION, STATE DEPARTMENT OF HEALTH

In February, 1920, through the efforts of the Connecticut Society for Mental Hygiene, a Division of Mental Hygiene was established by the State Department of Health of Connecticut. This was the first official recognition of the need of mental-hygiene activities by any state department of health. The 1921 legislature has appropriated $3,000.00 a year, for a period of two years, for the division, which will devote its resources to a demonstration of how certain mental patients, especially those paroled from state hospitals, may best be cared for in the community. The division has been conducted by Dr. William B. Terhune, Medical Director of the Connecticut Society for Mental Hygiene, under whose direction it will continue. Mrs. Helen K. Satterthwaite, of New Haven, has been engaged as field agent.

MENTAL HYGIENE SOCIETY IN LOUISVILLE

A society for mental hygiene has been organized in Louisville, Kentucky. A directorate of thirty members has been elected, from which an executive committee has been chosen. A salaried secretary has been appointed. The membership of the Louisville society may be drawn from the entire state of Kentucky, although the Louisville activities of the society are financed by the Welfare League. At a recent meeting, the executive committee approved of a budget for 1922 calling for six thousand dollars.

One of the activities of the society will be the supervision of the psychological clinic which serves local social agencies. At the request of the executive committee of the Louisville Society, the National Committee for Mental Hygiene has consented to make a mental-hygiene survey in Louisville.

The officers of the new society are: Dr. W. E. Gardner, President; Dr. Phillip Barbour, First Vice-President; Dr. James Bruce, Second Vice-President; Mrs. Emma Hegan, Third Vice-President; Dr. H. B. Scott, Third Vice-President; Frank S. Fearing, Secretary.

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